

10 YEARS OF

Chile Grows with You

(CHILE CRECE CONTIGO)

Key Components and Lessons Learned
for the Setting Up of Comprehensive
Child Development Support Systems



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of Comprehensive Child Development Support Systems**

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Index

Abbreviations

Introduction

- I. **Why Should We Ensure Conditions for the Development of all Children?**
- II. **System Management Model**
- III. **Guiding Principles and Keys to the Design, Implementation, and Improvement of the System**
 - 3.1 Leveraging All Resources
 - 3.2 Child Development as a Policy Outcome
 - 3.2.1 Differentiated Services: To Everyone According to Need at the Right Time in the Right Way
 - 3.3 Informed Decision-Making
 - 3.3.1 Design Based on the Available Evidence and Data
 - 3.3.2 Ongoing Evaluation and Monitoring
 - 3.4 Improving the Institutional Framework
 - 3.5 Recognition of Sectoral Technical Authorities and Policy Steering Body
 - 3.6 Intersectoral Management
 - 3.7 Key Management Tools
 - 3.8 Gradual Rollout that Respects the Integrated and Universal Nature of the System
- IV. **Bibliography**
- V. **Program Files**
 - 5.1 **Description of Programs Delivering Basic Social Services and Incorporating the Chile Grows With You (Chile Crece Contigo) Design**
 - 5.1.1 Legal registration of a birth and allocation of a Unique National Identification Number (Rol Único Nacional – RUN)
 - 5.1.2 National Immunization Program (Programa Nacional de Inmunización - PNI)
 - 5.1.3 National Complementary Feeding Program (Programa Nacional de Alimentación Complementaria - PNAC)
 - 5.1.4 General Regime Governing Explicit Health Guarantees (Régimen General de Garantías Explícitas en Salud - GES)
 - 5.1.5 Child Care or Nursery School for Infants under 2 and Preschool for Children Aged 2 to 4
 - 5.1.6 Family Allowance and Family Subsidy
 - 5.1.7 Mechanism for the Protection of Maternity
 - 5.2 **Chile Grows With You (Chile Crece Contigo) Programs**
 - 5.2.1 Educational Program

- 5.2.2 Biopsychosocial Development Support Program (Programa de Apoyo al Desarrollo Biopsicosocial - PADB)
- 5.2.3 Gestation and Birth Guide: Beginning to Grow (Guía de la Gestación y el Nacimiento - Empezando a Crecer)
- 5.2.4 Newborn Support Program (Programa de Apoyo al Recién Nacido - PARN)
- 5.2.5 Informative and Educational Materials for Children - “Discovering Together” (Acompañándote a Descubrir)
- 5.2.6 Nobody's Perfect Parenting Skills Workshop (Nadie es Perfecto)
- 5.2.7 Workshops on the Early Promotion of Motor and Language Development in the First Year of Life
- 5.2.8 Child Development Support Initiatives (Modalidades de Apoyo al Desarrollo Infantil - MADI)
- 5.2.9 Child Mental Health Support Program (Programa de Apoyo a la Salud Mental Infantil - PASMI)
- 5.2.10 Games Corner: Integrated Learning Support Program (Rincón de Juegos - RINJU)
- 5.2.11 Technical and Technological Assistance Financing Program for Inclusion (Programa de Financiamiento de Ayudas Técnicas y Tecnológicas para la Inclusión)

5.3 Chile Grows with You (Chile Crece Contigo) Tools

- 5.3.1 Information Management Tool: ChCC Registration, Referral, and Monitoring System (Sistema de Registro, Derivación y Monitoreo - SRDM)
- 5.3.2. Institutional Strengthening Tool: Municipal Strengthening Program (Programa de Fortalecimiento Municipal - PFM)
- 5.3.3 Innovation Tool: Competitive Fund for Childhood Initiatives (Fondo Concursable de Iniciativas para la Infancia)
- 5.3.4 Budget Management Tool: Agreements for Fund Transfers to Institutions (Convenios de Transferencias de Recursos a Instituciones)

Abbreviations

AF	Family Allowance (<i>Asignación Familiar</i>)
AFP	Retirement Fund Administrator (<i>Administrador del Fondo de Pensiones</i>)
AIDS	Acquired Immune Deficiency Syndrome
AUGE	Universal Access with Explicit Health Guarantees Plan (<i>Plan de Acceso Universal a Garantías Explícitas en Salud</i>)
BCG	Bacillus Calmette–Guérin
CAPNV	Proof of Live Birth Delivery (<i>Comprobante de Atención del Parto con Nacido Vivo</i>)
CASEN	National Socioeconomic Classification Survey (<i>Encuesta de Caracterización Socioeconómica Nacional</i>)
CASH	Know Your Child (<i>Conozca a Su Hijo</i>)
CCAF	Family Allowance Compensation Fund (<i>Caja de Compensación de Asignación Familiar</i>)
CECI	Early Childhood Education Cultural Center (<i>Centros Educativos Culturales de la Infancia</i>)
CEDP	Psychosocial Development Research Center (<i>Centro de Estudios de Desarrollo Psicosocial</i>)
CENABAST	Supply Office (<i>Central de Abastecimiento</i>)
ChCC	Chile Grows with You (<i>Chile Crece Contigo</i>)
CIGES	Health Training, Research, and Management (<i>Capacitación, Investigación, y Gestión en Salud</i>)
CLP	Chilean Peso
COMPIN	Committee for Preventive Medicine and Disability (<i>Comisión de Medicina Preventiva e Invalidez</i>)
CRC	Convention on the Rights of the Child
DEIS	Department of Health Statistics and Information (<i>Departamento de Estadísticas e Información de Salud</i>)
DHA	Docosahexaenoic Acid
DIBAM	Directorate of Libraries, Archives, and Museums (<i>Dirección de Bibliotecas, Archivos, y Museos</i>)
DIPRES	Budget Department (<i>División de Presupuestos</i>)
DSM	Diagnostic and Statistical Manual
DTP	Diphtheria, Tetanus, Pertussis
ECD	Early Childhood Development
ECLAC	Economic Commission for Latin America and the Caribbean

EEDP	Psychomotor Development Evaluation Scale (Escala De Evaluación del Desarrollo Psicomotor)
ELPI	Longitudinal Early Childhood Survey (<i>Encuesta Longitudinal de Primera Infancia</i>)
ENCAVI	Quality of Life Survey (<i>Encuesta de Calidad de Vida</i>)
ENIM	National Implementation Survey (<i>Encuesta Nacional de Implementación</i>)
ENS	National Health Survey (<i>Encuesta Nacional de Salud</i>)
EPsA	Abbreviated Psychosocial Evaluation (Evaluación Psicosocial Abreviada)
FIADI	Intervention Fund for Child Development Support (<i>Fondo de Intervenciones de Apoyo al Desarrollo Infantil</i>)
FONASA	National Health Fund (<i>Fondo Nacional de Salud</i>)
GES	Explicit Healthcare Guarantees (<i>Garantías Explícitas en Salud</i>)
HEPI	Public Space Designation for Childhood (<i>Habilitación de Espacios Públicos para la Infancia</i>)
HIB	<i>Haemophilus influenzae</i> Type B
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
INE	National Statistical Institute (<i>Instituto Nacional de Estadísticas</i>)
INFOGEST	Management Information (<i>Informes de Gestión</i>)
INRPAC	National Rehabilitation Institute Pedro Aguirre Cerda (<i>Instituto Nacional de Rehabilitación Pedro Aguirre Cerda</i>)
IPS	Social Security Institute (<i>Instituto de Previsión Social</i>)
ISAPRES	Private Health Insurer (<i>Institución de Salud Previsional</i>)
IT	Information Technology
JUNAEB	National Student Aid and Scholarships Board (<i>Junta Nacional de Auxilio Escolar y Becas</i>)
JUNJI	National Early Childhood Education Board (<i>Junta Nacional de Jardines Infantiles</i>)
KPI	Key Performance Indicator
MADI	Infant Development Support Modalities (<i>Modalidades de Apoyo al Desarrollo Infantil</i>)
MDS	Ministry of Social Development (<i>Ministerio de Desarrollo Social</i>)
MIDEPLAN	Ministry of Planning and Cooperation (<i>Ministerio de Planificación y Cooperación</i>)
MINEDUC	Ministry of Education (<i>Ministerio de Educación</i>)
MINSAL	Ministry of Health (<i>Ministerio de Salud</i>)
MMR	Measles, Mumps, Rubella
NEP	Nobody's Perfect (<i>Nadie es Perfecto</i>)

PADB	Biopsychosocial Development Support Program (<i>Programa de Apoyo al Desarrollo Biopsicosocial</i>)
PARN	Newborn Support Program (<i>Programa de Apoyo al Recién Nacido</i>)
PASMI	Child Mental Health Support Program (<i>Programa de Apoyo a la Salud Mental Infantil</i>)
PEC	Bring Your Child to School (<i>Para que Estudie Contigo</i>)
PEI	Institutional Educational Project (<i>Proyecto Educativo Institucional</i>)
PFM	Municipal Strengthening Program (<i>Programa de Fortalecimiento Municipal</i>)
IRA	Acute Respiratory Infection Program (<i>Programa de Infecciones Respiratorias Agudas</i>)
PKU	Phenylketonuria
PMD	Psychomotor Development
PMI	Childhood Improvement Program (<i>Programa de Mejoramiento a la Infancia</i>)
PNAC	National Food Assistance Program (<i>Programa Nacional de Alimentación Complementaria</i>)
PNI	National Immunization Program (<i>Programa Nacional de Inmunizaciones</i>)
RINJU	Games Corner (<i>Rincón de Juegos</i>)
RNI	National Immunization Records (<i>Registro Nacional de Inmunizaciones</i>)
RUN	Unique National Identification Number (<i>Rol Único Nacional</i>)
SDG	Sustainable Development Goal
SENADIS	National Disability Service (<i>Servicio Nacional de la Discapacidad</i>)
SEREMI	Regional Ministerial Secretariat (<i>Secretaría Regional Ministerial</i>)
SIGEC	Agreement Management System (<i>Sistema de Gestión de Convenios</i>)
SIIS-T	Integrated System for Social Information and Local Disaggregation (<i>Sistema Integrado de Información Social con Desagregación Territorial</i>)
SNIP	National Perinatal Information System (<i>Sistema Nacional de Información Perinatal</i>)
SNS	National Health Service (<i>Sistema Nacional de Salud</i>)
SQL	Structured Query Language
SRCeI	Civil Registry and Identification Service (<i>Servicio de Registro Civil e Identificación</i>)
SRDM	Registration, Referral, and Monitoring System (<i>Sistema de Registro, Derivación, y Monitoreo</i>)
SUF	Unified Family Subsidy (<i>Subsidio Único Familiar</i>)
SUSESO	Department of Social Security (<i>Superintendencia de Seguridad Social</i>)
TEPSI	Psychomotor Development Test (Test de Desarrollo Psicomotor)
UFRO	<i>Universidad de la Frontera</i>
UNICEF	United Nations Children's Fund
USD	United States Dollar
WHO	World Health Organization

Introduction

The evidence accumulated in the fields of neuroscience, cognitive science, pediatrics, and economics as well as the various lessons learned in matters of policies and social and child development programs have allowed for the construction of a solid foundation for advocacy of such programs, the growing commitment of nations, and the implementation of initiatives that, while they differ in scope, aim at the promotion of child development from the earliest stages throughout childhood. This has made important steps possible toward the fulfillment of the Convention on the Rights of the Child (CRC) as well as progress in the achievement of relevant Sustainable Development Goals (SDG). We have gradually come to understand that investment in the first years of life is strategic for countries and constitutes an ethical imperative for the construction of a more just and peaceful world.

Chile began setting up a system for child development protection and promotion in 2007, with the focus of social protection¹ and based on a **comprehensive** intersectoral management model that allows for personalized support along the trajectory of each child's lives, thus promoting the child's comprehensive development. This system ensures access to a set of **universal** services for all children in Chile, specifically focused on promoting child development in combination with the provision of **differentiated** services and benefits aimed at groups of children from socially or economically vulnerable families as well as **specialized** provisions for individual cases of at-risk or vulnerable children.

While challenges to the consolidation of the comprehensive childhood protection system known as Chile Grows with You (*Chile Crece Contigo* – ChCC) persist, progress and outcomes are evident. The system's design and setting up were developed based on a solid foundation of services and social and child programs already available in Chile when ChCC was first conceived.² Thus, a broad network of public healthcare services with sound nationwide outcomes as measured by infant and maternal health indicators served as the basis for the setting up of the axis program³ of the system, namely the Biopsychosocial Development Support Program (PADB, for its acronym in Spanish).⁴ This facilitated the rapid implementation and universalization of the system's

¹ The ChCC comprehensive childhood protection system was conceived as a subsystem of the Intersectoral Social Protection System, which takes other subsystems into account. For the purposes of this document, we refer to ChCC exclusively as a system and not as a subsystem.

² For more details about the services and programs available in Chile when ChCC was designed, please refer to Box 4: Basic and Extended Services Created within the ChCC framework.

³ In the case of Chile, those subsystems that form part of the Intersectoral Social Protection System require the operation of what is called an "axis" program, which performs personalized follow-up and support functions for beneficiaries of the respective subsystem.

⁴ For more details, see the Program Files section.

components, thus ensuring ample service coverage, sound design, loyalty levels on the part of the implementers, and positive levels of acceptance by the beneficiary population.

This pioneering experience in Latin America was inspired by the successful Head Start⁵ and Sure Start⁶ programs, and it has served as a basis for the design of similar initiatives with diverse scope in countries such as Colombia, Peru, and Uruguay.⁷ Its model for comprehensive and articulated services has been highlighted in a series of articles about child development published in the prestigious journal *The Lancet* (2016)⁸ as an example of a multisectoral program with wide scope for early childhood development.

Through its Investing in the Early Years⁹ strategy, the World Bank seeks to promote investment in early childhood, recognizing that this is one of the most cost-effective actions a country can implement to eliminate extreme poverty, drive shared prosperity, and create the human capital necessary to diversify and grow the economy. The present document therefore systematizes key design, implementation, and execution elements from the ChCC system in order to facilitate the sharing of learning experiences among countries interested in advancing the implementation of similar strategies.

The document is organized into 3 major sections. Section 1 contextualizes and synthesizes the principal theoretical arguments that support the relevance of ensuring adequate development conditions for all children, especially during their early years. Section 2 reviews the management model globally and presents an overview of the ChCC initiative as a comprehensive childhood support system. Section 3 exhaustively reviews key elements and criteria that have guided the design, implementation, execution, and fine-tuning of the system by identifying both tangible and non-tangible decisive factors in its construction aimed at enrichment through the exchange of experiences with other decision-makers facing similar challenges. The document is accompanied by a set of files describing programs and tools offered by the ChCC system, thus providing greater depth regarding those that are of the greatest interest to the reader.

⁵ Head Start is a US program that was gradually implemented starting in 1965 and provides comprehensive early education, healthcare, nutrition, and parental support services for children and low-income families. For more information, visit: <https://www.acf.hhs.gov/ohs>

⁶ Sure Start is an initiative of the British government implemented since 1998 with the objective of providing children with the best possible start in life through the joint provision of universal and differentiated child care services, early education, healthcare, and family support, with an emphasis on community development. For more information, visit: <https://www.education-ni.gov.uk/articles/sure-start>

⁷ Colombia: *From Zero to Always (De Cero a Siempre)*; Peru: *Childhood First (Primero la Infancia)*; Uruguay: *Uruguay Grows with You (Uruguay Crece Contigo)*. The lessons learned from the ChCC initiative have been the object of cooperation strategies between such diverse countries as Argentina, Belize, Brazil, Colombia, Ecuador, El Salvador, Equatorial Guinea, Honduras, Jamaica, Mexico, Mozambique, Panama, Peru, South Africa, Uruguay, and countries of the Eastern Caribbean.

⁸ Series from *the Lancet* journals. (2016).

⁹ For more information, <http://www.worldbank.org/en/programs/earlyyears>

I. Why Should We Ensure Conditions for the Development of all Children?

It is widely recognized that the foundations of our cerebral architecture are cemented through our earliest experiences and that as a result, early childhood experiences have profound repercussions for human development. These experiences influence our learning capacities, health, behavior, and in the long-term, our social relationships, work opportunities, and incomes. Thus, early childhood “is not only the period most vulnerable to risk factors but also a critical phase in which the positive effects of early intervention are most profound and in which the effects of factors that negatively affect development can be mitigated.”¹⁰ Investing in the early years of life is therefore one of the most effective and efficient actions countries can take to stop the transmission of intergenerational poverty, close inequality gaps, and promote the development of human capital. Furthermore, in light of the challenges we face in a world that is becoming increasingly globalized, developing those abilities acquired during early childhood, such as the capacity to reason, learn continuously, communicate effectively, and collaborate with others becomes a priority. Those who fail to acquire these skills at an early age or who do not manage to consolidate them throughout childhood and adolescence have a high probability of falling behind. Indeed, we know that millions of children in the world fail to reach their full potential due to poor nutrition, lack of appropriate stimulation, lack of learning opportunities, and early exposure to toxic levels of stress.

However, though we have made progress in understanding that children are born with relatively equal development potential, they also require adequate health, nutrition, and stimulation conditions for this potential to be deployed. Today, we have a better understanding of the tremendous challenge facing adults as they seek to provide stable environments with adequate nurturing care (Figure 1). The importance of building sensitive and responsive interactions has been recognized based on an understanding that emotional development is not simply another area of child development but rather part of the prism from which children expand their potential and therefore a fundamental basis for their positive and healthy development. Recognizing the complexity involved in building these interactions brings into sharper focus the need to support families in their fundamental role as the first actors called upon to provide this nurturing environment. To this end, parents and caretakers require appropriate conditions and strategies that provide support for strengthening their parenting abilities as well as contexts favorable to providing the time, energy, and tools needed for parents to positively interact with their children and perform their child-rearing tasks (Figure 2). This is how public policies aimed at supporting child development – and especially early childhood development – can make progress in confronting these new challenges with broader and more ecological multisectoral strategies

¹⁰ The Lancet. (2016).

combining healthcare services, education, and child development support together with social protection and family support policies.

In this context, multisectoral intervention models¹¹ are crucial. However, comprehensive child development protection and promotion systems go beyond the issue of multiple sectors. Rather, it implies building differentiated care models for each case in addition to addressing the complex challenge of public policy management (Figure 3). This implies providing support services based on each child's and family's needs on the understanding that ensuring the same development opportunities does not equate to supporting everyone equally. In turn, this implies following up in a personalized manner each child's development trajectory in order to respond to the needs faced by child and family, addressing risk factors, and strengthening development protection. It is therefore not sufficient to simply level the playing field for everyone. Continuing with this analogy, we must ensure that all children have an appropriate pair of shoes that enables them to play, run, and walk safely and comfortably. All children need a pair that fits, they will need a new pair as they grow up, it is pointless to provide only one shoe, the State is called upon to provide them with this equipment if their family cannot do so, and it is counterproductive to force a child to go barefoot, even more so if they have to play on an unsafe field. Providing everyone with the support they need to open up their maximum potential is both a strategic investment and an ethical imperative as well as a surmountable challenge and a huge opportunity for humanity. It is this understanding that makes the management model proposed by the ChCC initiative especially relevant because beyond the services and benefits it provides, it offers a way of organizing support services for child development and providing them in a differentiated manner according to the needs identified by local networks as they offer personalized support along the child development trajectory from pre-birth onward.

It should be noted that when the ChCC initiative was designed, the knowledge level and evidence available was less exhaustive than it is today. In 2006, concepts such as “windows of opportunity in child development” turned out to be revealing regarding strategic investment in early childhood, as were studies such as James J. Heckman's, the Nobel prize winner for economics.¹²

¹¹ Multisectoral programs entail the implementation of multiple service provisions in a coordinated manner and focus on reaching children through systematic interventions throughout early childhood. Their coverage levels may vary since some are aimed at vulnerable populations while others have a universal scope. However, one common characteristic is the need for high level of coordination between institutions. For their part, comprehensive programs imply an exhaustive focus on early childhood development (ECD). They include multisectoral interventions tailor-made for each child with individual follow-up of the ECD trajectory to ensure that all children receive appropriate multisectoral support, if necessary (Neuman, M.J. & Devercelli, A. E., 2013).

¹² Heckman, J. & Carneiro, P. (2003).

In 2007, *The Lancet*, a publication that had previously presented a series of articles with a focus on the more than 6 million preventable child deaths in developing countries, for the first time published a series about early childhood development. In three of these articles, it warned that around 39% of children under 5 in low and medium-income countries were at risk of not reaching their maximum development potential and reviewed evidence surrounding proximate determinants of this risk, with exposure to poverty emerging as a critical factor.¹³

In this context of increased availability of information and systematic studies, the design of the ChCC initiative integrated lessons in a positive and visionary manner based on the evidence available, the State's own experience regarding the design and management of social protection policies, and nationwide evidence regarding successful child healthcare and development programs.¹⁴ Strongly modeled from a perspective of child rights protection, this anchored in the commitments entered into in the Convention on the Rights of the Child (CRC).¹⁵

In recent years, knowledge surrounding early childhood development and the actions that promote it have grown exponentially. In a second series published in 2011, *The Lancet* examined and systematized evidence regarding the mechanisms and causes of child development inequality, its economic implications, and the risk and protection factors involved.¹⁶ More recently, almost 9 years after the initiation of ChCC, in 2016, a third series proposed a course-of-life perspective, emphasizing the need to provide conditions for children to receive nurturing care that is sensitive to their needs, especially during the first 3 years of life. Furthermore, the series advocates expanding effective and sustainable programs available in each country through the implementation of policies with large-scale multisectoral intervention in order to comprehensively reach families and children at the early childhood stage, highlighting ChCC as a positive example in this regard.¹⁷

Gradually, the systemic and comprehensive perspectives required by early childhood development policies have worked together with efforts to make progress beyond access to early education and basic nutrition and survival indicators. This has been accompanied by greater emphasis on intervention through programs that improve the quality of services,

¹³ Series from the Lancet journals. (2007).

¹⁴ The Presidential Advisory Council for Childhood Policy Reform mandated in 2006 by the Presidency of Chile in order to "implement a childhood protection system aimed at providing equal development opportunities for Chilean children from gestation" gathers national and international evidence available on these issues and mandates studies to be conducted, including "Evidencia internacional sobre políticas de la primera infancia que estimulen el desarrollo infantil y faciliten la inserción laboral femenina" (Vegas, E., Cerdán-Infantes, P., Dunkelberg, E., & Molina, E., 2006), which was conducted by the World Bank at the express request of the Council.

¹⁵ Ratified by Chile in 1990.

¹⁶ Series from the Lancet journals. (2011).

¹⁷ Series from the Lancet journals. (2016).

child-caregiver relations, the development of parenting skills, mental health, social protection for families, and access to child-friendly spaces, among the main aspects.

It is therefore unsurprising that today the ChCC experience is being taken up by organizations such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), or the prestigious journal *The Lancet* itself as an intersectoral strategy based on both global and local evidence regarding the impact of interventions integrated into early child development that currently serve as a model internationally.¹⁸

¹⁸ Richter, L. M. et al. (2016).

FIGURE 1

Components of nurturing and sensitive care

HEALTH

Prevention and treatment of diseases, immunizations and health checks, water, sanitation, and hygiene.

EARLY LEARNING

Continuity with elementary education, access to quality preschool education and child care, opportunities to explore and learn at home, books, toys and play materials, home visits.

SECURITY AND PROTECTION

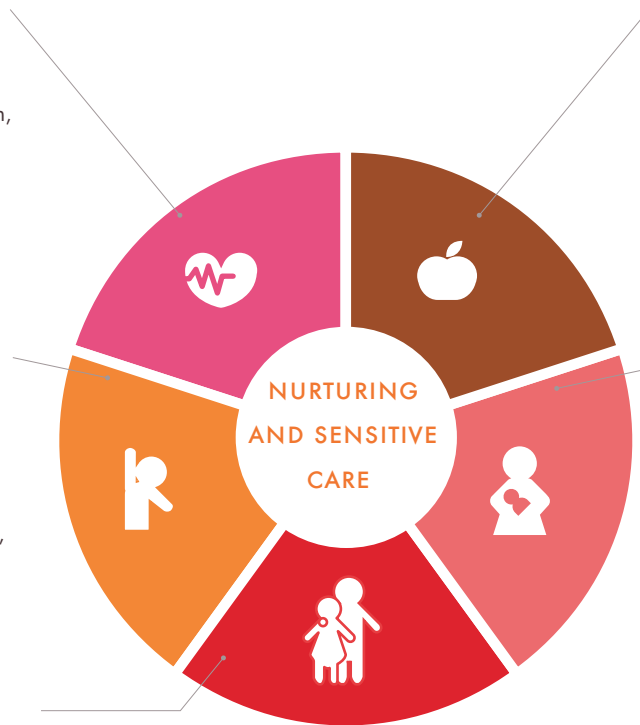
Minimizing adversities (abuse and neglect, violence), non-institutionalized family care and early intervention for at-risk children, birth registry.

NUTRITION

Dietary diversity, complementary nutrition, macro- and micronutrients, breastfeeding.

NEED-BASED CARE

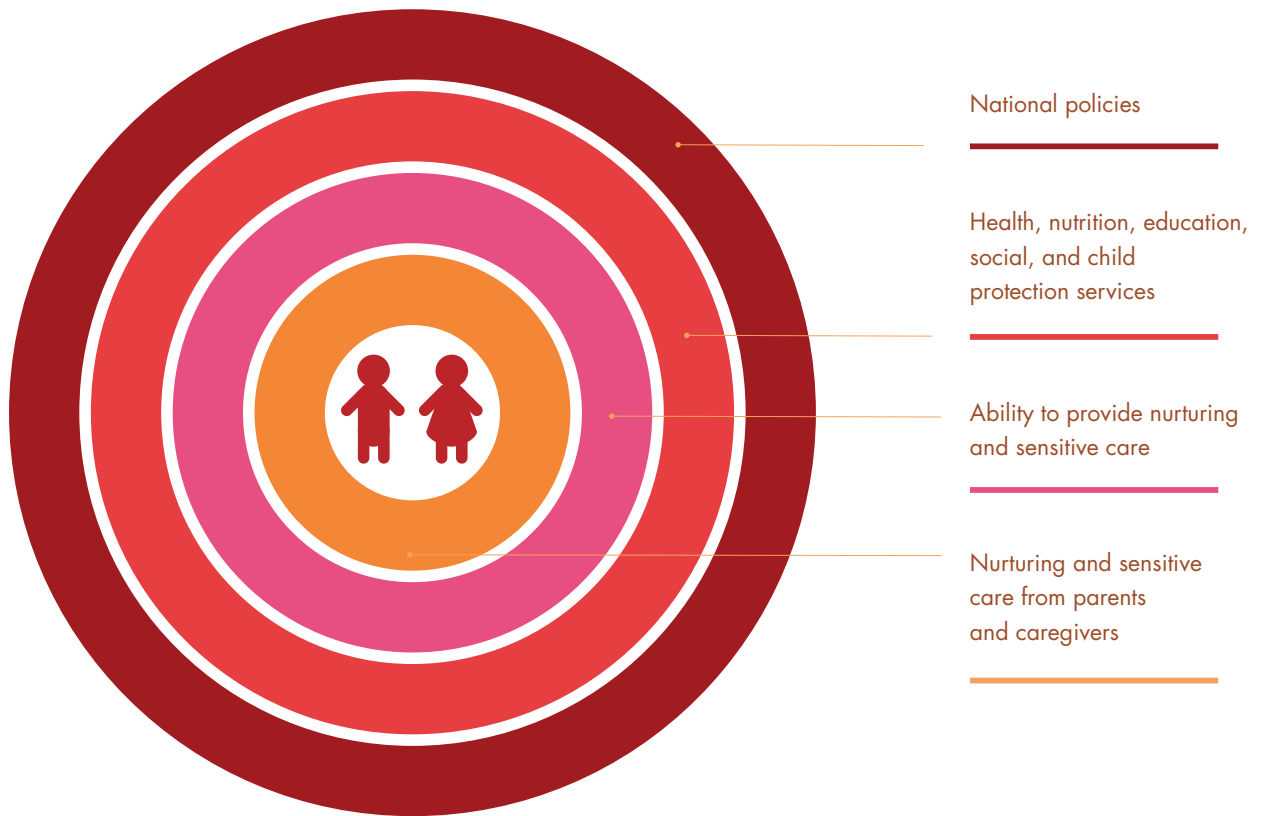
Responsive feeding, home visits, parenting skills programs, care routines, support for emotional development.



All of these domains or components interact and can be mutually reinforced as part of the process of child development. All are necessary to achieving nurturing and sensitive care through two-way interactions initiated by both child and caregiver supported (or interrupted) by the surrounding environment.

FIGURE 2

Nurturing and Sensitive Care Fostered by Supportive Environments

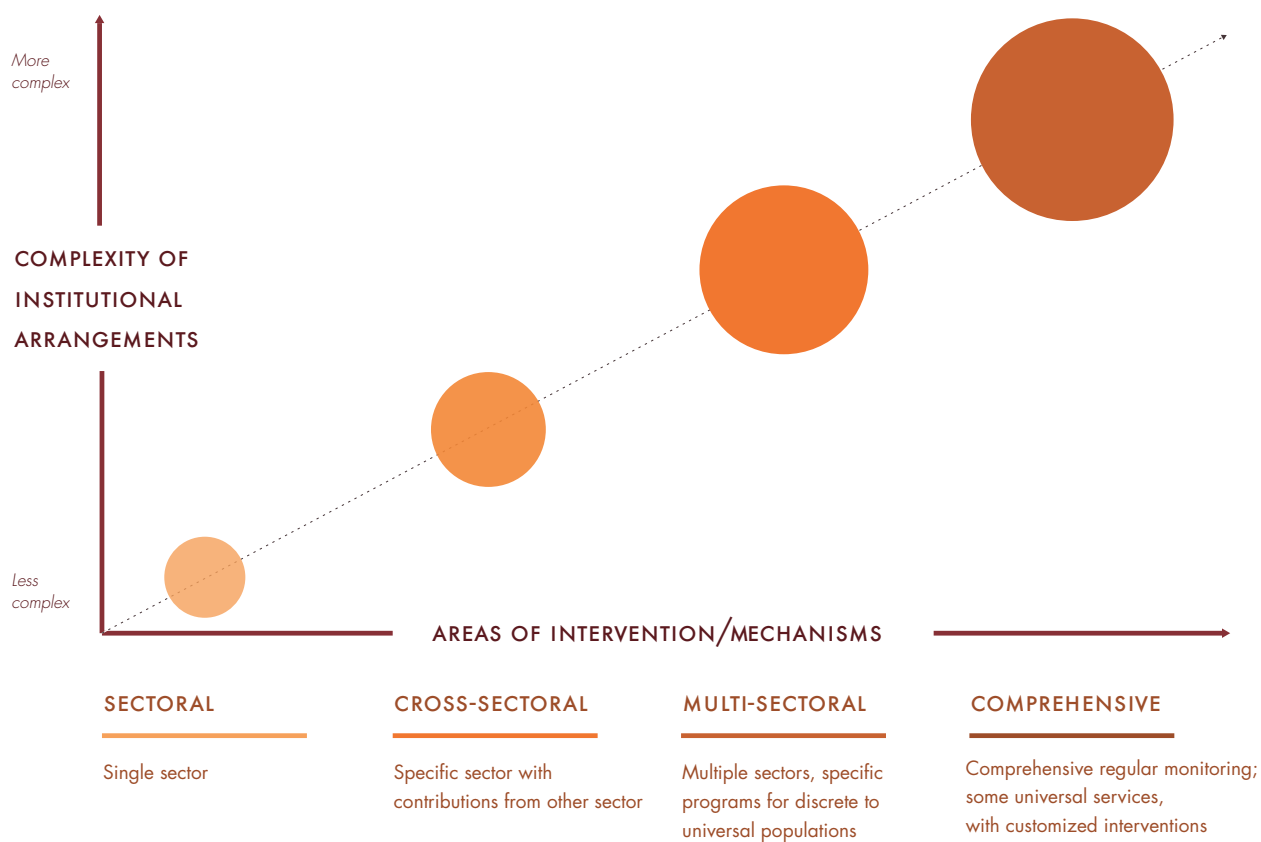


Nurturing care extends beyond families and requires the creation of:

FAVORABLE ENVIRONMENT for caregiver, family, and community	CONTEXT social, economic, political and cultural
Education and the physical and mental health of the parents, nutrition during pregnancy, prenatal care, safe childbirth, secure and clean neighborhoods, and absence of stigmas, among others.	Stable government with support for families, employment, housing, gender equality, and absence of extreme weather conditions, among others.

FIGURE 3

Types of interventions in early childhood development



II. System Management Model

“Early childhood development is growing throughout the world, and Chile’s experience is being promoted or mentioned as a global model.”

Dr. Judith Sullivan Palfrey, 2018¹⁹

The ChCC system is based on a management model that structures the differentiated deployment of a set of programs, benefits, social services, healthcare, and education to support the development of children according to their specific needs. Designed in 2006, it began a process of rapid implementation that provided national coverage by 2008 (Box 1; Figure 4). It is a comprehensive intersectoral policy with multiple components that monitor and support child development from gestation onward. Initially devised to support children until they enter the school system at the pre-kindergarten level (age 4), it is currently in the process of expansion to the middle-childhood phase (age 9), the age at which the first basic stage of elementary education and the national child health program conclude in Chile (Figure 5). Its foundations are based on the **ecological model** and a **focus on rights**, and it recognizes the family as the principal child development agent. It advocates a comprehensive development vision that addresses the social determinants of child development and integrates a **gender focus** as well as cultural and local belonging.

Its goal is to ensure maximum development potential deployment for all children in Chile and is characterized by a management model based on **belonging** and **opportunity** for the provision of services and benefits. To this end, it combines **universal, differentiated, and specialized** actions aimed simultaneously at the children themselves and their family for as long as they need it based on the principle of “supporting everyone based on their needs” (Box 2; Figure 6).²⁰

Supporting the development trajectory of children is implemented through the Biopsychosocial Development Support Program (PADB). Established as the system’s axis program, it is the gateway to ChCC and begins at the first prenatal checkup in the public healthcare system. In essence, the PADB fulfills a dual role: i) it ensures equal access to universal health services with defined quality standards essential for child development; and ii) it monitors child development and the potential presence of development risks in each child through the regular application of a set of screening instruments (Figure 7) as part of a regular child healthcare program in order to ascertain the need to activate access to the differentiated and specialized services on offer.

¹⁹ Palfrey, J. (2018). Dr. Palfrey is T. Berry Brazelton Professor of Pediatrics and Professor of Global Health and Social Medicine in Harvard University’s Medical School. She was Head of General Pediatrics at Boston Children’s Hospital and presided over the United States Academy of Pediatrics between 2009 and 2010.

²⁰ As the range of services included in ChCC is broad (see Box 2; Figure 6), a set of files describing the principal components of each program is included at the end of the present document.

Housed within maternal and child healthcare programs, the PADB program consists of a set of relevant services according to key life cycle stages (gestation, birth, child health checkups) that complement the regular actions of the National Child Health Care Program offered by the public healthcare system. Each service provision is defined along with its respective quality standards in a catalog that is updated annually and jointly defined by the Ministry of Health (MINSAL, for its acronym in Spanish) and the Ministry of Social Development (MDS, for its acronym in Spanish). Thus, all family and child contact points with the various service providers that make up ChCC are seen as an opportunity to detect social, family, and biomedical risk factors that can trigger an alert and activate the deployment of differentiated or specialized actions. These may be provided by the healthcare system itself or involve the intervention of other actors from the local network.

The management model is anchored in the shaping of local **networks** (Box 3; Figure 8) articulated to implement a joint work program that allows them to provide a differentiated response to each child and family based on defined standards through **case management**.²¹ Led by the municipalities and integrated by the actors directly responsible for providing the defined services, the main objective of the municipal networks is to articulate at the local level support for the development trajectory of children, monitor the system's various services, and perform referrals and other processes required to address situations that could affect children's normal development.

However, the management performed by ChCC municipal networks locally requires a support structure in all areas of responsibility as well as system management levels that make possible the resolution of key aspects of coordination and articulation at each level of government (national, regional, provincial, and local) (Figure 9).²²

On the recommendation of the Advisory Council that designed the basis of ChCC,²³ coordination at the national level is the responsibility of the Ministry of Social Development (MDS). This decision considered the relevance of designating an agency with intersectoral coordination functions regarding social protection matters and with growing experience in the management of intersectoral networks so that it could work in a coherent manner with

²¹ For further information, please consult: *Orientaciones técnicas para la gestión de redes Chile Crece Contigo*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2016/04/OT-Redes-2017-ChCC.pdf>

²² Chile is organized as a unitary state consisting of 15 regions (16 as of September 2018), 54 provinces, and 345 municipalities (*comunas*). Regional Ministerial Secretariats (SEREMI) represent the respective ministry for the region. The National Early Childhood Education Board (JUNJI) and the Integra Foundation are responsible for providing public early education services throughout the country. Each municipality performs local government functions, with the mayor acting as the highest authority.

²³ Presidential Advisory Council for Childhood Policy Reform. (2006).

all of sectoral institutions related to childhood. The MDS executes the ChCC budget,²⁴ and, when appropriate, assigns it to sectoral institutions in order for them to provide end-user services, thus ensuring a clear line of technical, administrative, and accountability responsibilities. At the regional level, the Regional Ministerial Secretariats (SEREMI, for its acronym in Spanish) for Social Development, in collaboration with the regional and provincial bodies in charge of healthcare and education, are responsible for supporting the operation of each municipal network. Finally, at the local level, leadership falls upon the municipality, which leads the municipal network through the municipal ChCC leader, while its members are in charge of providing the services promised.

In addition to this institutional structure, the system has a set of management support tools at its disposal.²⁵ Thus, the Registration, Referral, and Monitoring System (SRDM, for its acronym in Spanish) was set up as an information management tool and the Municipal Strengthening Program (PFM, for its acronym in Spanish) as an institutional strengthening tool, with agreements for resource transfers to institutions being its principal budget management tool and the grant fund initiatives functioning a tool for facilitating innovation.

The following section describes the elements that have been key to the design, setting up, and execution of the ChCC system and that may offer relevant lessons for other countries wishing to advance along that path. Chile currently offers an articulation and management model for services aimed at child development that is of interest for review and consideration. However, it is vital to keep in mind that beyond the programs and services the country offers its children and families today, it is desirable as well as hoped for that its specific components be reformulated as part of a continuous improvement process, a deepening and expansion of its scope, and adaptation to the requirements of future generations.

²⁴ The MDS executes the budget assigned by the Public Sector Budget Law for the execution of the ChCC system. However, it is important to highlight that the budget provides for complementary actions involving the execution of the system's service provisions given that many of its actions are financed through the regular budget of each sectoral ministry.

²⁵ Each of these is described throughout this document and is the object of a descriptive file to be found in the Program Files section.

Box 1 – Broad Consensus and Maximum Political Support for the Design and Implementation of Chile Grows with You (*Chile Crece Contigo*)

The Chile Grows with You (ChCC) initiative was developed following a specific process characterized by a broad technical-political consensus and on the basis of strong support from the Presidency of the Republic. Both of these elements favor rapid implementation designed to reach national coverage and achieve implementation as a complex, multisectoral management model within 2 years as well as sustainability over time despite political and governmental changes. Even though system design entered development in 2005 based on a set of pre-investment studies, it was in March 2006 that the Presidency initiated the setting up of a Presidential Advisement Council charged with preparing a diagnosis and proposal aimed at establishing a protection system for early childhood. This brought together 14 recognized experts from various political and technical perspectives, who, being in broad agreement, formulated the basic proposal from which the Chile Grows with You initiative arose.²⁶

The Advisement Council met for 3 months, and during that period held 46 interviews with national and international experts, social organizations, research institutes, professional associations, civil society groups, and other relevant public and private actors concerned with early childhood. The Council also held regional meetings with local organizations and actors throughout the country's (then) 13 regional capitals. This allowed for the preservation of local particularities and for direct dialogue with those providing child-related services. The Council also gathered contributions from thousands of children and adults made through the web portal specifically created for this purpose. The resulting proposal was discussed by an inter-ministerial committee, and even though not all of its recommendations were accepted, the foundations of Chile Grows with You arose from this proposal, with the creation of the initiative announced in October of the same year.²⁷

System implementation was defined as a strategic government objective, with an explicit mandate from the Presidency for the deployment of concrete actions, allowing for urgency to be given to the task of resolving any differences between sectors and facilitating their administrative and budget prioritization. This is how local Chile Grows with You networks were established in specific municipalities, and their first mission was to put in place a joint work plan aimed at formalizing decisions and information flows, implementation channels, and dissemination actions while receiving resources for this purpose. This process was marked by the implementation of a common discourse and set of goals through the dissemination of brief presentations and documents directed at executing teams. Each locality appropriated the system with different nuances according to their own organizational culture, gaps in care, local needs, and the particularities of its target population but in line with a collective purpose and a strong and determined approach.

The installation process was organized into two stages with the purpose of covering the first cohort of expectant mothers that would be incorporated into the system (Figure 4). During 2007, the first 159 municipalities (or almost half of the municipalities in the country) were thus integrated, having been selected based on shared criteria of available infrastructure and the highest initial management capacity in maternity wards. The remaining municipalities were integrated in 2008 based on lessons learned from the implementation of the initial set of municipalities.²⁸

²⁶ Presidential Advisement Council for Early Childhood Policy Reform. (2006).

²⁷ Government of Chile. (2011).

²⁸ Government of Chile. (2011).

FIGURE 4

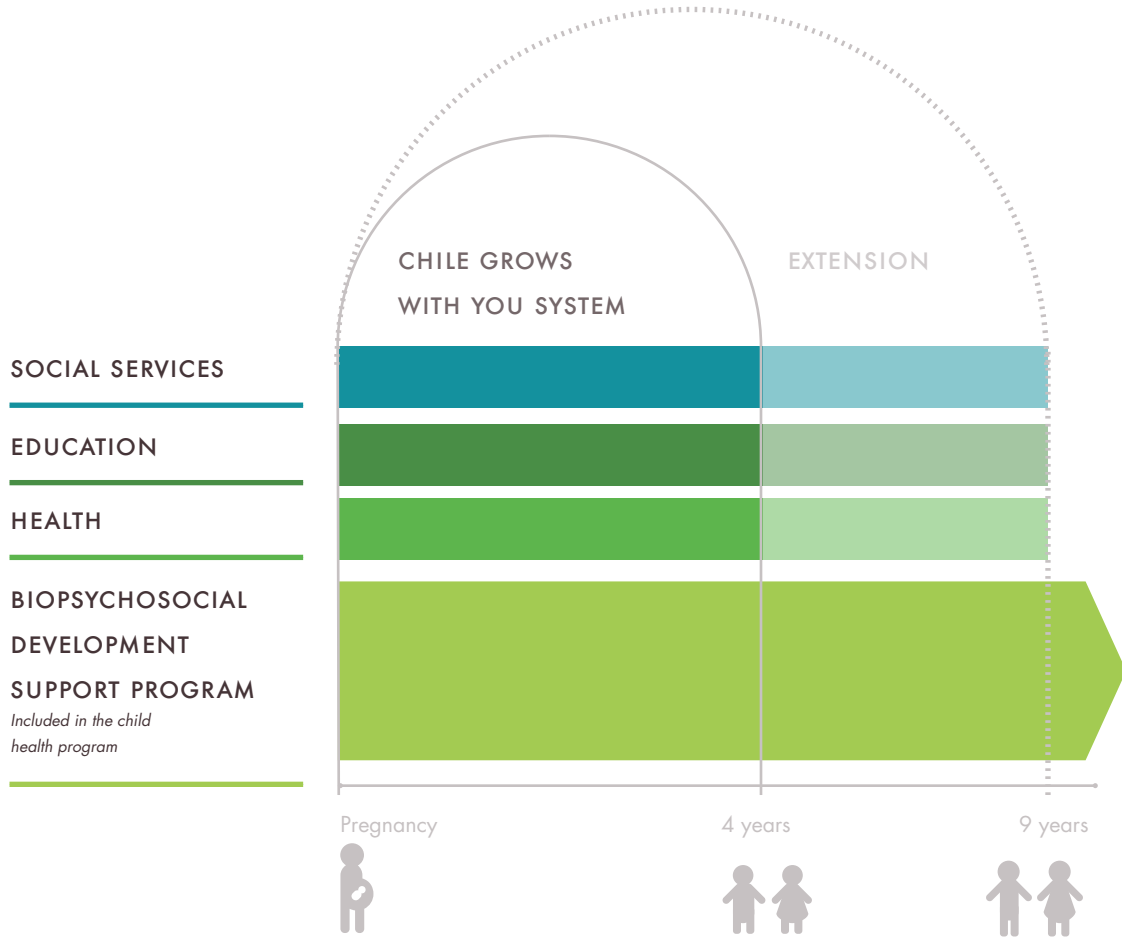
Chile Grows with You Coverage during Set-up Years, by Cohort

CHILE GROWS WITH YOU COVERAGE	2007	2008	2009
MUNICIPALITIES	159	345 (all municipalities)	345 (all municipalities)
PREGNANT WOMEN	47,683	202,729	204,935
BIRTHS	40,119	160,643	171,373
CHILDREN UNDER 1		168,823	173,733
CHILDREN AGED 1 TO 2		174,286	176,854
CHILDREN AGED 2 TO 4			324,338

SOURCE: Government of Chile. (2011).

FIGURE 5

Chile Grows with You Comprehensive Protection System for Early Childhood



SOURCE: Data compiled by the author.

Box 2 – Services Offered by Chile Grows with You (*Chile Crece Contigo*)²⁹

The programs, benefits, and services offered by the Chile Grows with You (ChCC) initiative can be categorized into three user levels, as described below:

Services aimed at all children and their families

Education Program: Through multiple platforms and universal coverage, the objective is to inform, educate, and sensitize the population regarding infant care, respectful parenting, and stimulation while favoring the development of positive family and community environments that contribute to the maximum deployment of early childhood development (ECD) potential.

Services for all children cared for in the public healthcare system

Biopsychosocial Development Support Program (PADB, for its acronym in Spanish): Providing universal and specialized services, this program is the gateway to the ChCC System (Axis Program), complementing and reinforcing maternal and infant healthcare actions in five areas: i) strengthening prenatal development; ii) customized childbirth care; iii) comprehensive care for hospitalized children; iv) strengthening of early childhood healthcare monitoring; and v) strengthening interventions for children in vulnerable situations or showing developmental lags. The program includes activities such as parental workshops, home visits, and the provision of educational materials, among others.

Newborn Support Program (PARN, for its acronym in Spanish): Offering universal coverage, this program's objective is for all children to receive the best possible healthcare from birth. It consists of 2 components: i) the provision of a set of implements (baby clothes), and ii) educational workshops for their use.

Targeted services for children of the most vulnerable 60% of the population³⁰

Free initial education for children from families belonging to the most vulnerable 60% of the population.
Free technical assistance for children aged 0 to 4 with some type of disability.

Targeted services for families with children from the most vulnerable 40% of the population³¹

Preferential access to public programs and services in programs such as foundation studies and work placement, improving homes and living conditions, mental healthcare, legal assistance, and prevention and care for domestic violence and infant abuse.

Each one of these programs is developed in further detail in the Program Files section.

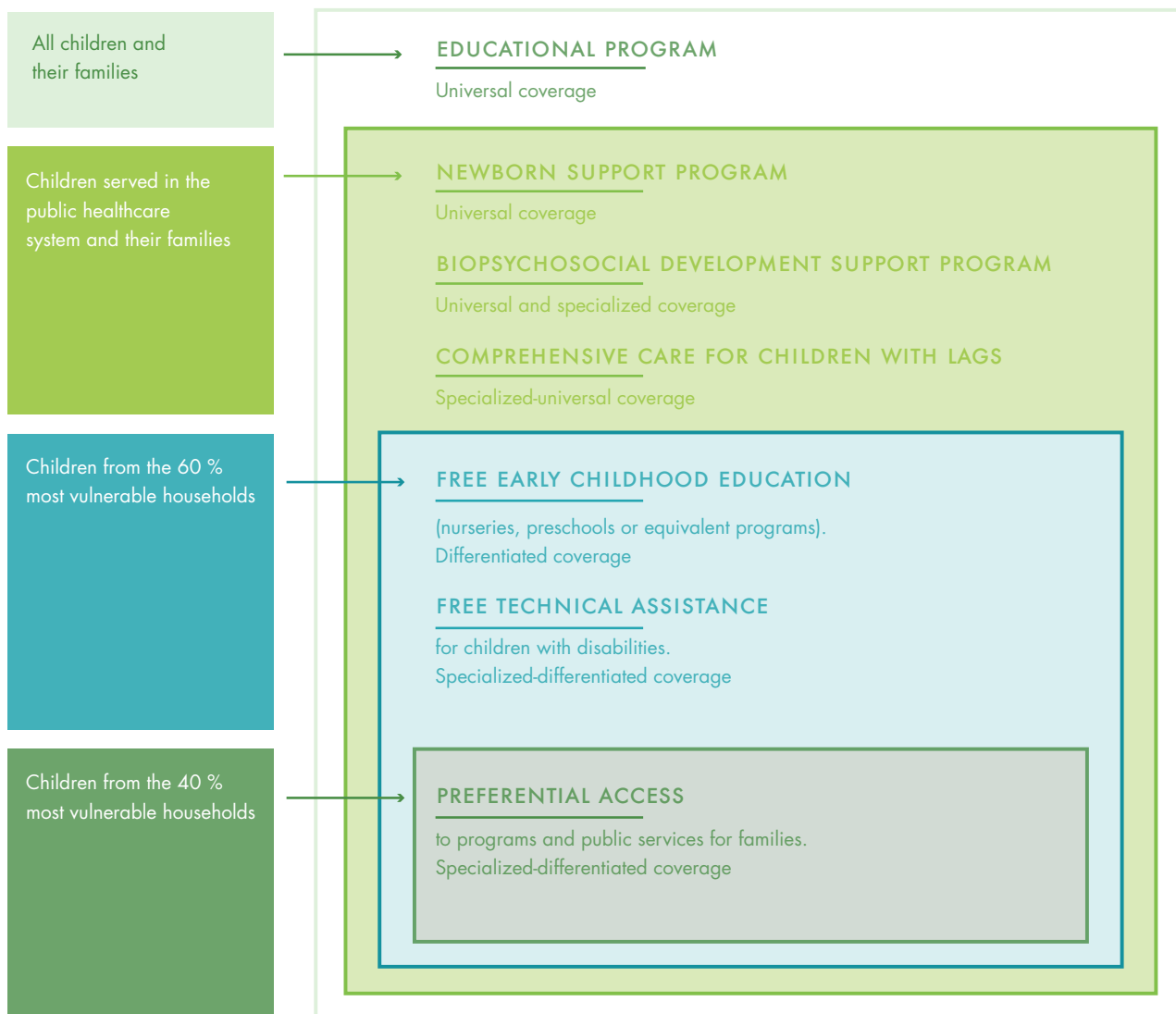
²⁹ Official Journal of the Republic of Chile. (2018). *Aprueba reglamento del subsistema de protección Integral a la infancia Chile Crece Contigo de la Ley No. 20.379*. Available at: <http://www.diariooficial.interior.gob.cl/publicaciones/2018/01/23/41964/01/1339434.pdf>

³⁰ Based on the socioeconomic classification of the Ministry of Social Development.

³¹ Ibid.

FIGURE 6

Chile Grows with You Services



Services aimed at children served by the public healthcare system are considered universal coverage since there are no prerequisites for access. It is up to each family to opt not to use the public network of services.

FIGURE 7. **Monitoring Child Development in Chile Grows with You**

GUIDELINES AND TEST	Initial prenatal health check	Dyad	MONTHS				
			1	2	3	4	5
PSYCHOSOCIAL EVALUATION SCALE (EPSA)	✓						
SCORE FOR RISK OF DYING FROM PNEUMONIA		✓	✓	✓	✓	✓	✓
NEURODEVELOPMENT EVALUATION PROTOCOL			✓				
EDINBURGH POSTNATAL DEPRESSION SCALE				✓			
BRIEF EVALUATION GUIDELINES FOR PSYCHOMOTOR DEVELOPMENT						✓	
GUIDELINES FOR DETERMINING RISK FACTORS FOR MALNUTRITION BY EXCESS						✓	✓
CHILD SAFETY GUIDELINES							
PSYCHOMOTOR DEVELOPMENT SCALE (EEDP)							
GUIDELINES FOR CHILD ORAL HYGIENE EVALUATION							
PSYCHOMOTOR DEVELOPMENT TEST (TEPSI)							
CHILD HEALTH QUESTIONNAIRE AGES 5-9							
ABBREVIATED CONNERS TEST							

EXCERPTED AND UPDATED BASED ON: Ministry of Health. (2014).



				YEARS								
6	8	12	18	2 ▲	3	3,5 ●	4 ▲	5	6 ● ▲	7	8	9
✓	✓	✓										
✓												
		✓		✓								
		✓		✓	✓	✓	✓	✓				
✓	✓											
	✓		✓									
			✓			✓		✓	✓			
					✓							
								✓	✓	✓	✓	✓
										✓		✓

● Consultation with nutritionist

▲ Consultation with dentist

Box 3 – Local networks: Chile Grows (*Chile Crece Contigo*) with You Municipal Networks³²

At the local level, coordination and articulation for effective support along the child's developmental trajectory is the responsibility of Chile Grows with You (ChCC) municipal networks, which bring together various local institutional actors. This constitutes the concrete expression of the system's policy implementation.

Two network modalities are distinguished, both articulated and coordinated by local municipal ChCC leaders or municipal officials appointed by mayors for these purposes:

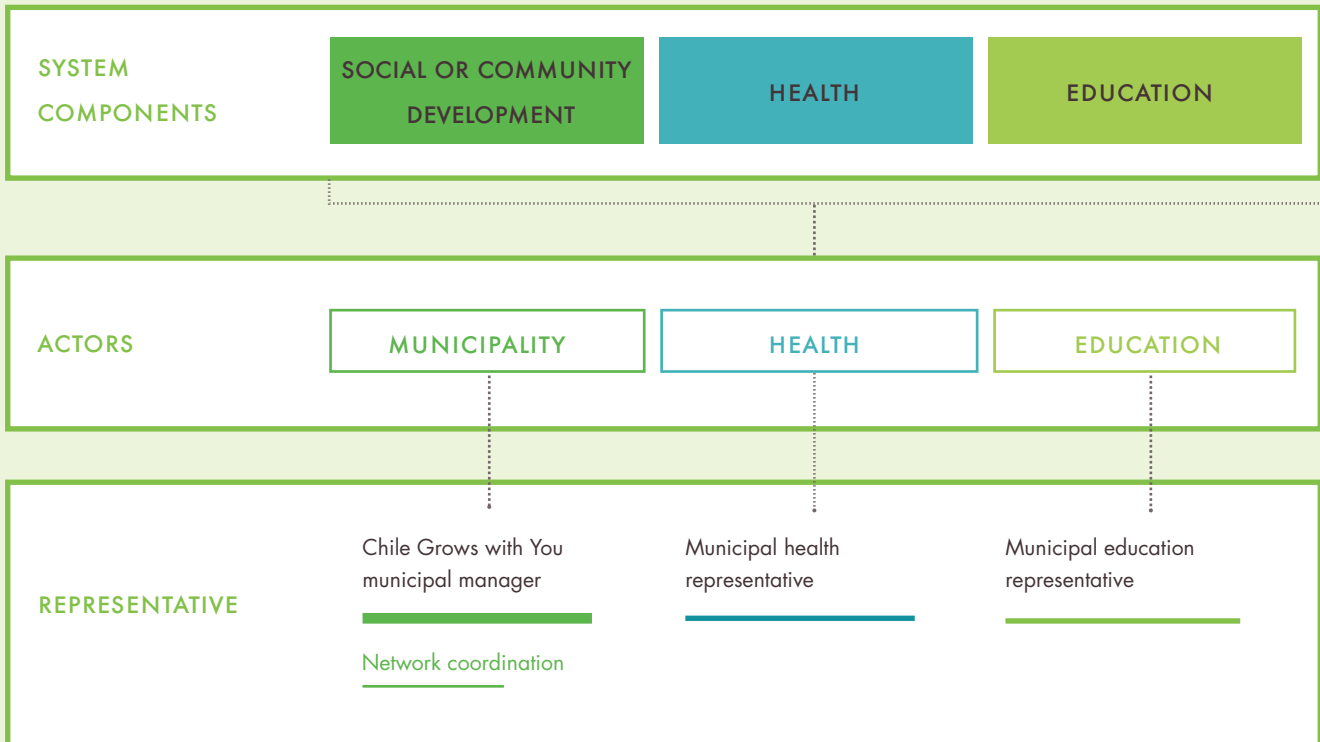
Basic ChCC Network: This consists of representatives of municipal social units from the health sector and early education centers. Its principal management tool is the Registration, Referral, and Monitoring System (SRDM), an online platform aiming to provide visibility on beneficiary care, generate vulnerability alerts allowing for the timely activation of defined actions, register and monitor the implementation of available services, and support local network management.

Expanded ChCC network: This network organizes the set of institutional actors from other departments or local services taking actions focused on early childhood, particularly those safeguarding against situations of psychosocial vulnerability and the infringement of rights. Special protection institutions, civil society organizations, police forces, or any other organization linked with work being done with children and families at the local level are incorporated in this network.

³² Government of Chile. (2018).

FIGURE 8

Structure of Basic Chile Grows with You Network



Under the Chile Grows with You initiative, a network is an interconnected system in which individuals or institutions are joined, sharing their resources, contacts, and knowledge as well as their doubts, problems, and limitations. In this way, a form of collaborative work is generated, where tasks are confronted collectively in order to ensure that children reach their full developmental potential.

FIGURE 9

Chile Grows with You Management Support Structure



The Inter-ministerial Committee for Social Development is part of the legal structure of Chile Grows with You and plays a leading role in the system. This entity has the legal authority to approve all changes to the list of services through which Chile Grows with You supports children and their families.

SOURCE: Compiled by author and updated based on Government of Chile. (2011).

III. Guiding Principles and Keys to the Design, Implementation, and Improvement of the System

This section elaborates on the principles and criteria (explicit or otherwise) that guided the main decisions taken in the designing of the Chile Grows With You (ChCC, for its acronym in Spanish) system, giving shape to guidelines and to a road map that may contain relevant elements for decision-makers wishing to pursue similar policy strategies.

3.1 Leveraging All Resources

It is vital in designing and implementing public policies that all resources (institutional, human, and financial) are leveraged effectively and efficiently regardless of their source (public, private, community, or family) or the sectoral or local level from which they emerge. To this end, an inventory must be made of all existing resources with a view to combining them and giving them new meaning within the framework of an inter-sectoral system. Following this principle, an essential component in the design of the ChCC system was the inclusion of the country's pre-existing range of services and programs in the areas of healthcare, education, and social protection (Box 4) while harnessing existing human, material, and institutional capital. In addition, the system's actions were driven by two complementary visions: i) organizing the range of services aimed at children and their families into a comprehensive and systemic management model; and ii) ensuring that the system contained the various integrated services aimed at promoting child development deemed essential as well as feasible while extending or creating new services and benefits where necessary. Both objectives sought to extend the reach of existing policies and programs and to integrate them in response to users' needs. Above all, the aim was to broaden access to these policies and programs following equivalent quality standards for every child or family that may require them as a right guaranteed under the public policy. The key to this model resides in identifying which of the available services each child requires by monitoring each child's developmental trajectory.

To effectively leverage all resources, an exhaustive assessment must be made of the state of existing policies and programs in the area, distinguishing between levels of consolidation of available program offerings and gathering institutional lessons in order to reinforce those programs or actions displaying the greatest effectiveness or promising the greatest impact (Figure 10).

Putting together such a system therefore requires a set of basic services that are either already consolidated or in the process of being consolidated,³³ operate on a regular basis, and able to be effectively brought together with a view to identifying any improvements and additions that may need to be made. This entails not only identifying existing programs but also identifying the actors responsible for their delivery, the programs' coverage, and how they work to ensure access and quality as well as the factors that may facilitate or impede their implementation. Comparing this assessment with the analysis of the essential areas for child development will then determine whether these services need to be supplemented by new services.

It is also crucial to identify the usual points of contact between service providers and the target population and to take advantage of existing services so as to avoid creating new operations while launching the system. In the case of Chile Grows with You, the country took advantage of its very high rate of public health coverage and its regular contact with families through regular antenatal check-ups and periodic child health check-ups in anchoring the system's core program (Biopsychosocial Development Support Program – PADB).

When it came to defining the package of services that would be included in ChCC, two relatively new concepts in public policy in Chile combined virtuously: i) guaranteed service; and ii) preferential provision.³⁴ Guaranteed services are services the State commits to delivering within given timeframes and quality standards to all those who meet the criteria without limitation of any other type (as opposed to using quotas or priority lists to choose from within a group of those meeting these criteria); these services are therefore universal in nature within a given target population. Meanwhile, preferential provision can be understood as priority access by a subset of the population to an array of services when on equal terms with other population subsets not covered by the corresponding system. One such example is priority access to employment programs awarded to caregivers of children covered by ChCC

³³ It is important to note that the basic services package underpinning ChCC consisted of a broader set of services than that recommended by the World Health Organization (WHO) in these areas (World Health Organization, 2003). For example, while the WHO recommends four gestational check-ups, the average in Chile that year was six (Government of Chile, 2011). ChCC was therefore built upon a basic package that went beyond the bare minimum.

³⁴ These concepts arose in parallel with the law governing the *Chile Solidario* program in an effort to overcome extreme poverty alongside the Universal Access with Explicit Health Guarantees Plan (AUGE) in 2004. *Chile Solidario* was subsequently reconstituted as the Security and Opportunities subsystem but maintained the concepts of guarantees and preferential provision. Several years later, AUGE became known merely as Explicit Health Guarantees (GES), under which rules commit the health system to ensuring: i) access to promotion, protection, access to healthcare, and recovery for a list of health issues that is updated every three years; ii) opportunities to receive care (with maximum timeframes for the provision of guaranteed health services); iii) quality (through registered or accredited providers); and iv) financial protection.

provided they meet program criteria and are among the 40% most vulnerable households in the country.

ChCC therefore incorporated services that were already guaranteed, including: i) the National Immunization Program (PNI, for its acronym in Spanish) or the National Supplementary Nutrition Program (PNAC, for its acronym in Spanish); ii) services already in existence but with limited coverage (such as the right to a day nursery or kindergarten for the most vulnerable families); iii) other services for earlier stages of child development but with limited access or without clear standards (such as home visits or educational workshops for parents); iv) innovative initiatives but with narrow roll-out and reach (such as some local initiatives in personalized and integrated birth care); and v) creating a range of new services in previously uncovered areas (such as the Newborn Support Program – PARN, for its acronym in Spanish).³⁵

The same principle guided the first task facing the ChCC municipal networks, which consisted in creating an "opportunity map" which a view to systematically placing all available program resources and services available at the local level into a set aimed at the system's beneficiary families and children (Box 5).

Several years later, a similar operation was conducted to design the main components of an extension of ChCC to children aged up to 9. Drawing heavily on a study entitled Proposed Plan in Support of Biopsychosocial Development for the Design of the Universal System of Guarantees of the Rights of Children and Adolescents³⁶ as well as on the Integrated Social Program Database,³⁷ the available range of public services for children and families was compared to the developmental needs identified for this group in an effort to evaluate the technical, political, and administrative feasibility of each component required to determine its inclusion or exclusion.

³⁵ A description of the services that have been extended, improved, or created as part of ChCC is provided in Box 4.

³⁶ Araujo, M., Moraga, C., Irarrazabal, M., Hoogma, A., Barrera, F., Bedregal, P., Mercer, R. (2015).

³⁷ Created in 2012, this database provides a list and official description of the social programs run by the Chilean government. Since 2014, it has been publicly accessible online at: <http://www.programassociales.cl>

Box 4 – Basic and Extended Services Created within the Chile Grows with You (Chile Crece Contigo) Framework

Basic services³⁸ and experience in intersectoral management upon which the design and implementation of the Chile Grows with You (ChCC) initiative are based.

In 2006, when the ChCC initiative was designed, the country possessed a significant foundation of social and early childhood services upon which the system could be installed. Among these, the following stand out:

- 1. Civil registration of newborns and assignment of a Unique National Identification Number (RUN, for its acronym in Spanish) issued by the Civil Registry and Identification Services after certification of natural filiation between mother and newborn child through the issuance of a Live Birth Care Certificate by the healthcare professionals in charge of the delivery.**³⁹
- 2. Broad, diversified, locally expanded universal health care network.**⁴⁰ Provision of healthcare services following national directives from the Ministry of Health through the National Health Service (SNS, for its acronym in Spanish), which consists of 29 decentralized healthcare services distributed throughout the country through a network of approximately 196 hospitals of diverse complexity, secondary outpatient care institutions, and a network of 845 primary care centers, most of which are administrated by local governments (municipalities)⁴¹ and which began the implementation of the Family Healthcare Plan in 2000.
- 3. Access to deferred payment and free healthcare services for the most vulnerable groups.** It should be noted that the Chilean government guarantees the **right to free healthcare for pregnant women up to 6 months from the birth of the child, including pregnancy checkups, delivery assistance, and post-partum monitoring, as well as for the newborn child up to the age of 6.**⁴²
- 4. Consolidated full coverage programs, including:**
 - **National Immunizations Program (PNI, for its acronym in Spanish)** for protection against immuno-preventable diseases.
 - **National Food Assistance Program (PNAC, for its acronym in Spanish),** which offers access to healthy and safe foods with the purpose of improving the nutritional situation of women who are pregnant or breastfeeding and of children under 6.
 - **Women's Health Program,** with a comprehensive health model and care strategies differentiated by complexity level.⁴³
 - **Children's Healthcare Program,** which in 2004 normed stimulation and the evaluation of psychomotor development in children under 6.⁴⁴
 - **Acute Respiratory Infection Program (IRA, for its acronym in Spanish),** with the main objective of decreasing morbidity and mortality from acute respiratory infections, specifically by reducing mortality from pneumonia in infants under 1.⁴⁵
 - **Strengthening of Neonatal Intensive Care:** Equipping neonatology units, providing a continuous training plan nationwide, a nationwide program for the use of surfactant and indomethacin, implementing polyclinics tracking premature births, and publishing National Neonatal Guidelines (2005), among other actions.⁴⁶

³⁸ The present document defined as "basic services" those services that already existed when the ChCC initiative was designed, such as some of the social policy services in effect at that time.

³⁹ In Chile, 231,383 births were recorded in 2006, of which 230,810 (99.75%) received professional delivery care, 94 (0.04%) received no professional delivery care, and 479 (0.21%) could not identify what type of care was received. Ministry of Health, Department of Statistics and Healthcare Information (DSHI). (2017).

⁴⁰ Presidential Advisement Council for Early Childhood Policy Reform. (2006).

⁴¹ Ministry of Health. (2011).

⁴² Ministry of Health. (1985).

⁴³ Ministry of Health. (1997).

⁴⁴ Ministry of Health. (2004).

⁴⁵ Girardi, G. B., Astudillo, P. O., & Zúñiga, F. H. (2001).

⁴⁶ Ministry of Health. (2005).

- **Emergency Medical Care** (Primary Healthcare Emergency Units, and pre-hospital and hospital rescue).⁴⁷
 - **Explicit Healthcare Guarantees (GES, for its acronym in Spanish):** Installing a social protection system based on the inalienable rights of citizens.⁴⁸
5. **Preschool (or early) education coverage in segments of the population with the greatest socioeconomic vulnerability.**
 6. **Network of initial education and care centers** (nurseries and preschools), mainly through the National Preschool Council and the Integra Foundation, with a total of 2,009 and 954 units, respectively,⁴⁹ **with special attention given to children in situations of poverty or social vulnerability.**⁵⁰ The 2006 National Socioeconomic Classification Survey (CASEN, for its acronym in Spanish) showed that **preschool (early) education coverage for children under 6 totaled 37.8%**, through which the National Early Childhood Education Board (JUNJI, for its acronym in Spanish) and Integra cared for almost half of the children at this level (or 14.7% of the relevant population). Furthermore, **coverage by both institutions of children under 4 belonging to the 1st and 2nd quintiles totaled 25%.**⁵¹

Institutional Experience in Intersectoral Management: Birth of the Social Protection System

The development of a new social policy that cares for the most vulnerable families in the country in a prioritized manner began development in Chile in 2000. In 2002 the Bridge (*Puente*) program was created, aimed at citizens in situations of extreme poverty. Through this program, public services on offer were linked along three axes of action: **(i) services offered by the government without these having to be requested; (ii) setting up a network; (iii) and taking the family as the focus of intervention.** Its operating system was put in place at the local level, establishing municipalities as the direct executors of the program and forming **local intervention networks convened by municipalities and consisting of representatives from all public and private institutions and organizations providing services to families in situations of extreme poverty.**⁵²

In parallel, the design of a strategy for strengthening **coordination of public offerings in the area of social protection and promotion** was initiated and established as part of the *Chile Solidario* program and stipulated by Law No. 19.949 of May 17, 2004. This introduced a new form of institutionalization as well as an **information system against which homogeneous focal criteria and the selection of beneficiaries** could be defined. This program consisted of 4 key components: i) psychosocial support for beneficiary families offered by the Bridge program; ii) protection vouchers for the family; iii) guaranteed monetary subsidies (family benefits in place prior to *Puente* and *Chile Solidario*); and iv) preferential access to promotional programs, employment benefits, and prevention. The Bridge program thus became the gateway to *Chile Solidario*. Both programs were coordinated by the **Ministry of Planning, now the Ministry of Social Development**, which, through the Executive Secretariat of the *Chile Solidario* system, **took charge of managing economic resources, coordinating the network of participating institutions, monitoring progress, and evaluating outcomes.**

These and other public policies were reflected in positive results indicators, but with significant inequalities according to socioeconomic and regional groupings. In 2006 this enabled Chile to offer coverage for over 98% of professional childbirth care, close to 90% in prenatal monitoring care in the public healthcare system, with an average of 6 contacts during gestation, and very high rates of child healthcare monitoring coverage during the

⁴⁷ Government of Chile. (2011).

⁴⁸ Presidential Advisement Council for Early Childhood Policy Reform. (2006).

⁴⁹ Ministry of Education. (2010).

⁵⁰ In 2006, JUNJI selected children through the poverty line method (based on the per-capita income of families, namely destitute, poor but not destitute, or not poor, and the Integra Foundation did so using a factsheet gathering information regarding the child's vulnerability, housing background, and family unit income, each with its own weighting. Ministry of Finance, Budget Division (DIPRES). (2008).

⁵¹ Ibid.

⁵² Economic Commission for Latin America and the Caribbean (ECLAC). (2011).

first years of life.⁵³ However, 21.9% of children under 4 lived in poverty (16.7% in poverty and 5.2% in destitution). This is considerably higher than related averages for the general population (10.5% in poverty and 3.2% in destitution).⁵⁴ Between ages 2 and 3, 26.5% of children attended preschool, and only 6.0% of children under 2 attended nurseries. In contrast, attendance by children from the highest income brackets was four times that of the poorest quintile, and almost 30% of children under 5 failed to reach all of the development milestones expected for their age group.⁵⁵

Extended Services⁵⁶ within the Chile Grows with You Framework and Implementation 2009

- Biopsychosocial Development Support Program (PADB):
 - Comprehensive home visits covering registration, the setting of goals, and identification of at-risk population through screening instruments incorporated into ChCC (Abbreviated Psychosocial Evaluation – EPsA);
 - Prenatal education workshops through the production of audio-visual support materials and technical guidelines for executing teams, favoring the standardization of activities;
 - Personalized care and support for the birth process through the transfer of resources for restructuring concrete maternity services favoring intimacy and support prior to and during delivery, geared toward the availability of comprehensive care delivery rooms in hospitals;
 - Skin-on-skin contact between mother and baby at the time of birth through the setting of relevant achievement goals;
 - Universal epidemiological monitoring of psychosocial risk factors during the first years of life through the drafting of recommendations and guidelines for healthcare teams;
 - Monitoring of the mother-child dyad in primary healthcare. This refers to the joint monitoring of mother and newborn, allowing for evaluation of the interaction between them.
 - Comprehensive home visits through registration, the setting of goals, and prioritization of the at-risk population or with development deficits;
 - Stimulation rooms for infant development.
- Free early education for children from families belonging to the most vulnerable 40% of the population;
- Single family subsidy guaranteed to all households meeting eligibility requirements;
- Technical assistance for children with special needs from families belonging to the most vulnerable 60% of the population;
- Preferential access to public services (foundation studies, work placement, home and habitability, mental healthcare, among others);
- Guaranteed access to *Chile Solidario* in relevant cases.

⁵³ Government of Chile. (2011).

⁵⁴ Ministry of Social Development. (2007).

⁵⁵ Government of Chile. (2011).

⁵⁶ In this document, services offered by social policies already in effect but whose coverage was increased or quality improvements made as a result of the ChCC initiative are defined as "extended."

Services Created by Chile Grows with You⁵⁷

2009

- Biopsychosocial Development Support Program (PADB):
 - Increase in the duration of the first prenatal checkup to 40 minutes;
 - Application of Abbreviated Psychosocial Evaluation (EPsA);
 - Delivery of educational materials to expectant mothers (gestation and birth guide);
 - Family support during the gestation period;
 - Effective bonding of expectant mothers, children, and family with services available at the local level through the activation of the Communal Network;
 - Introduction of the *Purita Mamá* dairy beverage for pregnant women and wet nurses as part of the National Food Supplement Program (PNAC);
 - Comprehensive postpartum care through the incorporation of interdisciplinary teams in maternity hospital work;
 - Neurological development deficit prevention for hospitalized newborns through the transfer of resources for the adaptation of the physical environment of neonatology units and team training for the development of nursing plans in accordance with this objective;
 - Development deficit prevention in hospitalized children through the creation of spaces for encouraging play and the design of cabinets on wheels for transfer and use of educational ludic materials in the hospital context (game carts and game chests);
 - Delivery of Discovering Together educational materials for children in primary healthcare centers;
 - Infant Development Support Modalities (MADI, for its acronym in Spanish);
- Group workshop for the development of parental competence as part of the Nobody's Perfect initiative;
- New Born Support Program (PARN).

2013

- Group workshop for the early promotion of language and motor development

2016

- Child Mental Health Support Program (PASMI, for its acronym in Spanish)
- Games Corner (RINJU, for its acronym in Spanish)

⁵⁷ The social intervention services especially designed for ChCC along with new financial resources associated are considered new services.

FIGURE 10

Consolidation Stages for Available Programs and Associated Desired Actions

TYPE OF OFFERING	DESCRIPTION	ACTIONS
CONSOLIDATED SERVICES	Relevant policies and programs with broad coverage and positive outcome indicators that will serve as an initial base.	Guarantee access to these services in a pertinent and timely manner for every child that requires them, with equivalent quality standards throughout the regions.
SERVICES UNDERGOING CONSOLIDATION	Relevant policies and programs with limited coverage or with gaps in access that, despite positive outcome indicators, need to be extended or fine-tuned to ensure their availability to every child that needs them.	Expansion and improvement of available services. Creation of suitable conditions for implementation on a mass scale (physical and human resources, generation of technical standards, quality standards and capabilities for implementation, among others).
POTENTIAL SERVICES	Relevant policies and programs with promising results at the national or international level that should be incorporated into the available services to ensure inclusion in the most significant areas promoting comprehensive child development.	Gradual installation through pilot programs or adaptation and planned scaling.

Box 5 – Local Intersectoral Network Opportunity Map

This management tool consists in a range of resources made available to local Chile Grows with You (ChCC) communal networks for carrying out adaptations to the management process. Its objective is to identify local actors as well as the functions of the various institutions that make up the local network. Its construction enables the listing and description of entire updated offers for the targeted local population, which any institution integrated into the communal network should have access to.

Following the technical guidelines for ChCC Network Management,⁵⁸ the minimum content of this opportunity map should consist of:

- Name of program or service;
- Institution where it is implemented;
- Information of the person in charge, including email, address, and telephone number;
- Specific care provided;
- Recipients and entry requirements;
- Application period, if relevant;
- Business hours, location where the access procedure is performed, and associated cost;
- Source of financing.

⁵⁸ Ministry of Social Development. (2015).

3.2 Child Development as a Policy Outcome

The ultimate goal of ChCC management and implementation is to ensure that the rights of children are respected and that the developmental outcomes that enable them to reach their full potential are achieved. This requires the existence of comparable development targets for every healthy child throughout the life cycle. With this in mind, the program must be managed in such a way that makes it possible to identify, visualize, summarize, and evaluate these results. In Chile, evaluation and stimulation of psychomotor development was included almost 50 years ago in the National Child Health Program. Since the 1980s, this evaluation has been part of regular care during child health check-ups,⁵⁹ for which a set of evaluation instruments is used (Figure 7).

In light of evidence suggesting that child development occurs in the interaction between protective and risk factors, ChCC actions are designed to strengthen the former and reduce the impact of the latter as part of a two-way process. In parallel with the establishment of the ChCC system, the monitoring of children and of their families was strengthened with a view to activating intervention alerts when developmental risks are detected.

ChCC was established gradually, following the growth of cohorts of children from gestation, with the result that the overall life cycle of the system's various components increased as the beneficiary cohorts grew older. In 2007, for instance, a guideline for the early detection of psychosocial risk was added to the first prenatal check-up (Abbreviated Psychosocial Evaluation – EPsA, for its acronym in Spanish) to screen for risk factors that may affect the well-being of every pregnant woman and the child's comprehensive development before birth.⁶⁰ From 2008, the monitoring of child development was enhanced with the addition of the concepts of developmental lag and risk.⁶¹ These concepts refer to the possibility of a child attaining a normal score on the psychomotor development scale but with one or more areas in deficit, which is considered to be a development risk factor requiring early intervention.⁶² In operational terms, this means that the detection of a lag generates a warning that triggers an intervention under the Child Development Support Program (MADI, for its acronym in Spanish).⁶³ This intervention entails the provision of a health service, even when not performed in a health center proper and independently of whether or not the child attends early education. Standards for monitoring and

⁵⁹ Bedregal, P., Villaroel, L., Padilla, O., & Valenzuela, P. (2017).

⁶⁰ Detailed information is available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Nota-Metodologica-EPsA_2010.pdf

⁶¹ The term "lag" originated in the field of education, where it describes a student who fails to achieve universal educational targets (Ministry of Health, 2008).

⁶² Ministry of Health. (2008).

⁶³ For more details, see the Program Files section.

screening for development risk are updated periodically.⁶⁴ A description of the supervision of child development and existing instruments is provided in Box 6.

As observed by the ChCC team, it is important to consider that child development assessments make sense only if they give rise to differentiated interventions according to the needs detected, with the aim of reversing or mitigating such a situation. Thus, performing these tests results in the activation of services such as integrated home visits, referrals to specialists at the secondary care level, referrals for appropriate stimulation methods, and linkages with other services and benefits of the ChCC communal network.⁶⁵

Achieving a given impact in child development requires quality standards being defined for all of the system's services (which can take shape or be improved, adjusted, or expanded during policy implementation). It also requires the setting up and strengthening of mechanisms designed to accredit and audit these standards in addition to the creation of instruments aimed at monitoring and evaluating the services themselves and the policy in general. While other details of the policy monitoring process will be addressed below, it is important to note that when ChCC emerged, not all of its components were equipped with such standards: in fact, many of them were improved as the system was rolled out. These standards were also modified in response to the needs of the technical teams for more guidance and of the administrative teams for support while giving an accurate account of the basis of specific outcomes, processes, and impacts. In the case of services provided by the system's core program, standards were drawn up via the formulation of a catalog of services that has been revised and updated annually since 2007 to reflect adjustments and additions to ChCC (Box 7). In the case of specific services, standardization has been achieved thanks to the development of technical standards or guidelines and methodological notes designed to guide the actions of the various service providers (Box 8).

A vital ingredient in upholding quality is a clear understanding that quality cannot be sacrificed in the interest of coverage, and that if there are major budget or technical restrictions, quality should be favored over exponential increases in coverage. In such cases, a plan should be developed and scaled up gradually and sustainably over time. In Chile, the system was set up gradually following successive cohorts while ensuring minimum standards, which have gradually been improved upon and benefited from the recognition that only quality services generate the desired impact on child development and prevent potential iatrogenic damage

⁶⁴ For example, the National Program for an Integrated Approach to Child Health was launched in 2013, followed in 2014 by the Technical Standard for the Supervision of Children Aged 0 to 9 under Primary Healthcare, both of which available at: <http://www.minsal.cl/salud-infantil>. In recent years, the Ministry of Health (MINSAL) has been gathering the necessary evidence to modify or update the development screening instruments used in the public health system.

⁶⁵ Government of Chile. (2011).

due to poor-quality programs. To ensure quality, it is also necessary to invest in preparing adequate human resources through continuous training programs, generating suitable working conditions, and gradually building up the necessary skills among all actors intervening or interacting with public policy at the local level. Upholding service quality also requires effective, reliable, and mandatory quality assurance and control mechanisms at the level of service providers and delivery. These mechanisms must continuously monitor standards in areas such as infrastructure, equipment, supplies, coordination, financial resources, and the skills and capacities of human resources.

In ChCC, for the purpose of monitoring quality standards in the services provided under the PADB catalog, a National Implementation Survey (ENIM, for its acronym in Spanish)⁶⁶ of PADB implementation was used until 2015, reporting on aspects such as physical facilities, supplies, human resources, and procedures. However, this survey was discontinued after a few years as the level of compliance was quite high and did not make it possible to identify differences in compliance between healthcare institutions. In the case of the Child Development Support Program implemented with resources from the Intervention Fund for Child Development Support (FIADI, for its acronym in Spanish), monitoring guidelines address aspects such as infrastructure, equipment, the training level of staff, and appropriate recordkeeping. This takes place on a self-reporting basis by the municipal networks, with quality categorized as "basic," "intermediate," or "advanced," with random supervision from regional support levels such as the Regional Ministerial Secretariat (SEREMI) of the Ministry of Social Development (MDS). However, this is one area that requires strengthening and improvement so as to establish greater and better mechanisms designed to supervise and monitor compliance with predetermined standards for the various services provided by the Chile Grows with you initiative.

⁶⁶ Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/2-Informe-final-Encuesta-nacional-de-implementacion-programa-de-apoyo-al-desarrollo-biopsicosocial-2008-2009.pdf>.

Box 6 – Principal Development Screening Tools and Risk Factors for Chile Grows with You Infant Development⁶⁷

The monitoring protocol regularly accessed by the population through the public healthcare system considers the application of the following screening tools under the plan detailed in Figure 7:

- **Expectant mother’s psychosocial risk:** Through the Abbreviated Psychosocial Evaluation (EPsA) applied to all pregnant women during the first pregnancy checkup and aimed at detecting vulnerabilities requiring the prioritization of healthcare actions with a psychosocial focus, the following situations are viewed as alerts triggering specialized services: (i) late entry, after 20 weeks of gestation; (ii) education below Basic Elementary 6 (less than half the school years required by the State); (iii) expectant mother less than 18 years old (adolescent pregnancy); (iv) the presence of depression symptoms; (v) substance use or abuse (alcohol, cocaine paste, cocaine, marijuana, or non-prescription medications); (vi) gender-based violence; (vii) unintended/unwanted pregnancy; and (viii) insufficient family support.
- **Risk of death from pneumonia score:** Applied during the first year, this measures the diverse risk factors associated with postnatal death from pneumonia (after the first 28 days of life), such as malnutrition, congenital malformations, or tobacco use on the part of the mother, among others.
- **Neurological development evaluation protocol:** Applied at the age of 1 month with the objective of identifying changes representing relevant risk factors for health or development and early investigation of neurosensorial disorders in breastfeeding children.
- **Maternal depression:** This is measured on the Edinburgh postpartum depression scale, which was created to assist primary care professionals in the detection of mothers suffering from postpartum depression. The process requires an application time of less than 5 minutes and is applied at 2 and 6 months after childbirth.
- **Psychomotor Development (PMD):** This is evaluated through the application of a set of complementary instruments and in accordance with the life cycle.
- **Brief Measure:** This consists of a qualitative scale with items selected from the Psychomotor Development Evaluation Scale (EEDP, for its acronym in Spanish) and allowing for early detection (taking approximately 5 minutes) of changes for each of the test ages. It is applied when the child is 4, 12, and 24 months of age.
- **Psychomotor Development Evaluation Scale (EEDP) from 0 to 2 years** is applied in 20 to 30 minutes and considers 4 developmental dimensions: (i) motor skills; (ii) language; (iii) social interaction; and (iv) coordination. It is applied in infant health checkups from 8 to 18 months.
- **Psychomotor Development Test (TEPSI, for its acronym in Spanish) from 2 to 5 years** is applied in 30 to 40 minutes and evaluates infant development in three areas: coordination, language, and motricity. It is applied during infant health checkups at age 3.
- **Risk of malnutrition due to excess:** This is observed through a measure of determining factors such as history of gestational diabetes, exclusive maternal breastfeeding of less than 4 months, among others. It is applied at various points between the ages of 4 months and 5 years.
- **Infant safety:** This is monitored through a self-applied measure applied to parents regarding hazardous conditions for children in the home, such as toxic substances within their reach, unprotected power points, among others. It is administered to parents during infant health checkups at 6 months as well as during following health checkups.

⁶⁷ Most of these tools are applied regularly during health checkups. The Abbreviated Psychosocial Evaluation (EPsA) was drafted within the ChCC design framework, and its application began with the implementation of the system. Other evaluations, such as the Edinburgh postpartum depression scale, were made universal with the implementation of ChCC.

- **Infant oral measure:** This instrument aims to ensure a comprehensive, systematic, and periodical evaluation of oral health and incorporates the basics of promotion and prevention. It is applied at various points from 18 months as part of infant health checkups.
- **Infant health questionnaire for children aged 5 to 9:** This was created to be applied or self-applied in the school context and includes the detection of alert signs and the evaluation of pubertal development.
- **Evaluation of symptoms associated with hyperactivity:** This is measured through the Abbreviated Conners Test and applied at ages 7 and 9.

Box 7 – Chile Grows with You Services⁶⁸

This consists of a catalog standardizing and containing all services financed by the Biopsychosocial Development Support Program (PABD – Axis Program) and, since their respective years of incorporation, the Newborn Support Program (PARN) and the Child Mental Health Support Program (PASMI). It is established annually and is the instrument governing the transfer of resources from the Ministry of Social Development to the Ministry of Health and later from the Health Services to the municipalities. In the latter case, the resources transferred are added to the health center’s budget and operate as a complementary payment, which means implementing the services defined in the catalog under the norms and goals determined therein within regular health programs. In summary, these resources correspond to budget increases associated with performing actions in addition to those considered in the Family Health Plan. The catalog also contains indicators and verifiers for submitting accounts.

⁶⁸ The 2018 services catalog is available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2018/01/Catalogo-Prestaciones-ChCC-2018-Ok.pdf>

Box 8 – Chile Grows with You Regulations and Technical Guidelines

The standards for the principal services offered have been gradually defined and perfected through the creation of regulations, technical guidelines, and methodological notes aimed at executing teams through manuals or training. The issues being regulated and standardized are also a reflection of the gradual consolidation of the Chile Grows with You (ChCC) initiative and the emergence of requirements over time:

- 2007 Methodological note for the application of Abbreviated Psychosocial Evaluation (EPsA) regulations
- 2008 Reproductive process personalized care manual for the healthcare teams
- 2008 Support and follow-up manual for the psychosocial development of children aged 0 to 6
- 2008 Oral health promotion and prevention program for preschool children
- 2009 Methodological note for the use of Gestation Guide⁶⁹
- 2009 Technical guidelines for comprehensive home visits for biopsychosocial development in early childhood
- 2009 Fundamentals for operating an Intersectoral Social Protection System
- 2009 Workshop facilitator manual for Nobody's Perfect parenting skills
- 2009 Nobody's Perfect group facilitators trainer manual
- 2010 Breastfeeding manual for the application of new regulations and concepts in the development of activities performed by health services
- 2010 Guide for the promotion of infant development in local management
- 2010 Complementary methodological note on Discovering Together series
- 2010 Technical guidelines for psychosocial support in emergency situations and disasters for families with children aged 0 to 5
- 2011 Technical guidelines for the psychosocial care of hospitalized children in neonatal and pediatric services
- 2012 Technical guidelines for Infant Development Support Methods (MADI)
- 2012 Promotion guide for active paternity and the co-responsibility of upbringing for ChCC professionals
- 2013 National Early Childhood Healthcare Program with comprehensive approach
- 2014 Technical guideline for the supervision of children from ages 0 to 9 in primary healthcare
- 2015 Newborn Support Program (PARN) methodological note
- 2015 Technical guidelines for the management of ChCC networks
- 2015 Workshop manual for the early promotion of motor and language development in the first year of life
- 2016 Technical guidelines for care in breastfeeding clinics
- 2016 Technical guidelines for the creation of the Public Space Designation for Childhood Program (*Programa de Habilitación de Espacios Públicos para la Infancia – HEPI*)
- 2017 Operating manual for breastfeeding with user guidelines on equipment
- 2017 Technical guidelines of the Child Mental Health Support Program (PASMI) for children aged 5 to 9
- 2017 Technical note for ChCC expansion

⁶⁹ Updated or modified in different versions on various occasions.

3.2.1 Differentiated Services: To Everyone According to Need at the Right Time in the Right Way

Safeguarding quality implies not only setting and meeting standards but also determining how appropriate the services provided are for the population they target. Standards that contain inbuilt flexibility for the delivery of a given service allow it to be tailored to local realities or to the specificities of the population subset without lowering quality while responding adequately to the needs of this group. In addition, putting in place effective mechanisms designed to ensure that services are provided at the right time also help safeguard quality. In other words, quality should be determined not solely by the content of a service but also by how it is delivered.

While it may be desirable for the overall design of each component of the system to have basic and verifiable quality standards, flexible delivery modes are enriching only if the implementing teams are able to tailor the delivery of their services to the particular features of the beneficiary population in accordance with various criteria such as latent risk, ethnicity, or locality. The design of the FIADI fund provides a particularly interesting example of this observation. This fund was set up at the start of the ChCC initiative to finance the Child Development Support Program (MADI)⁷⁰ while providing municipal networks with the resources needed to tailor initiatives to their needs and local context (Box 9). Thus, it is local government acting through the set of actors that form each ChCC network that ensures that the right services are delivered over its territory at the right time. In a similar vein, another interesting strategy is provided by the Equivalent Early Education Methods Program, which predated ChCC and was incorporated into it from the start, in that it enables the creation of programs offering equivalent early education strategies to those found in nurseries or kindergartens in localities or among populations that for various reasons do not have access to a conventional early education system (Box 10).

⁷⁰ For more details, see the Program Files section.

Box 9 – Intervention Fund for Child Development Support

Aimed at creating means of caring for children with developmental lags or deficits, the Intervention Fund for Child Development Support (FIADI) consists of a budget transfer of annual resources to the Chile Grows with You (ChCC) communal networks through resource transfer agreements between the Ministry of Social Development and the municipalities. It allows local actors to choose from a budget framework defined at the national level based on demographic and local criteria and invests its resources from a menu of possibilities, including mobile stimulation service, stimulation room at municipal branches or health centers, and home stimulation care.⁷¹ Each modality has technical guidelines available standardizing and supporting its actions. However, it is the ChCC communal network that defines who the services belong to and creates the most appropriate combinations given local realities. In this way, the Fund delivers autonomy and potential for direct participation at the local level in order to enable equivalent services to those articulated within the Biopsychosocial Development Support Program (PADB) for the selection and timely care of its users.⁷²

Box 10. Early Childhood Education Equivalency Programs⁷³

Chile Grows with You (ChCC) ensures access to nurseries, preschools, or equivalent for children in the 60% most socioeconomically vulnerable segment of the population. This program facilitates the authorization of non-conventional early childhood programs in order to expand the delivery of services and complement those offered by the National Early Childhood Education Board (JUNJI) and the Integra Foundation. This helps bridge the gap in coverage for population subgroups that, due to specific characteristics or local reasons, fall outside of the conventional early childhood education system.

*“Know Your Child” (CASH)*⁷⁴ is a program aimed at providing alternative preschool education to vulnerable and at-risk children under 6 living in sparsely populated rural areas or marginal urban areas by delivering pre-primary educational strategies to parents or caregivers. This is done through educational meetings led by community instructors, with support from orientation manuals.

The Childhood Improvement Program (PMI) is designed to provide education to children under 6 through an educational partnership with community organizations in urban areas and concentrated or sparsely populated rural areas.⁷⁵ It is delivered through participatory and open community initiatives led by local volunteers.

Early Childhood Educational Cultural Centers (CECI) provide education and meals to children under 6 living in concentrated rural or urban areas without access to formal education.⁷⁶ These on-site programs are implemented in locations with greater social vulnerability.

The Centers for Children with Temporary Primary Caregivers Program is an initiative aimed at supporting the care and development of children aged 6 to 12 by coordinating recreational, play-based, and sports activities and meals while primary caregivers are occupied with seasonal labor.^{77,78}

⁷¹ For more information about the Infant Development Support Modalities (IDSMS), see Program Files section.

⁷² Updated information based on the Government of Chile. (2012).

⁷³ Equivalency programs are also known as "non-conventional" programs.

⁷⁴ Ministry of Social Development. (2017a).

⁷⁵ Ministry of Social Development. (2017b).

⁷⁶ Ministry of Social Development. (2017c).

⁷⁷ Ministry of Social Development. (2017d).

⁷⁸ Chile is a country with a significant agricultural sector. Many workers carry out seasonal tasks during the summer months, which coincides with the period during which educational centers are closed for the long vacation.

3.3 Informed Decision-Making

It is vital that intervention strategies be devised on the basis of the strongest and most significant evidence with regard to their potential effect in achieving the objectives set. This is supplemented by the development of new evidence or pilot experiments that generate knowledge with a view to incorporating other services and benefits or to redesigning them for a better policy. In addition, all services included in the regular catalog must benefit from sufficient technical support.

3.3.1 Design Based on the Available Evidence and Data

ChCC is a system based on evidence and data available at the time of its design, and has been subsequently refined as new information has emerged. The definition of its original components resulted from a series of studies, including: i) the findings and recommendations of the Presidential Advisory Council on Early Childhood Policy (Box 1); ii) 15 pre-investment studies that guided the design of some specific components in the field (Box 11); and iii) a broad process of negotiation among the various sectoral ministries within the framework of a Cross-ministerial Technical Committee for Childhood,⁷⁹ in which the proposals made by the Presidential Advisory Council were evaluated one by one, including analyses of their technical and economic feasibility, so as to determine their inclusion (or exclusion) in the design of ChCC.

Moreover, improvements also arise from the frequent use of data generated by the delivery of services. This includes both national and international evidence on child development, such as available sociodemographic and administrative data. One such case has been the strong drive to address child mental health problems at an early stage, currently reflected in the Child Mental Health Support Program (PASMI, for its acronym in Spanish), which arose from the growing body of national evidence on high prevalence rates of mental disorders among the population aged 4-11 in Chile as well as their poor coverage in terms of care.⁸⁰

⁷⁹ This committee brought together the General Ministerial Secretariat of the Presidency, the Ministry of Finance, the Ministry of Labor and Social Welfare, the Ministry of Housing and Urban Development, the Ministry of Justice (now the Ministry of Justice and Human Rights), the National Women's Service (now the Ministry of Women and Gender Equality), the National Council for Culture and the Arts (now the Ministry of Cultures, Art, and Heritage), the Ministry of Education, the Ministry of Health, and the Ministry of Planning (now the Ministry of Social Development).

⁸⁰ 31.9% of children aged 4-11 in Santiago de Chile suffer from a mental disorder (DSM-IV) (Vicente B., et. al. 2012).

Box 11. Pre-investment Studies⁸¹

In designing the Comprehensive Protection System for Early Childhood, the Government of Chile commissioned a series of pre-investment studies. During 2005, related research was conducted on experiences of implementation, both public and private, as well as perception studies, taking into account different realities and areas of the country. The topics covered were as follows:

1. Design of spaces and objects for integral childbirth
2. Families and the learning process
3. Teen pregnancy and family dynamics
4. Teen pregnancy and available resources
5. Habitability issues and children
6. Current regulations for children
7. Mapuche parenting principles
8. Aymara parenting principles
9. Systematization of humanized birth care in the Aymara population
10. Systematization of non-conventional educational programs developed in Pehuenche territory
11. Systematization of psycho-affective, educational, and formative support program for teen pregnancy
12. Systematization of early childhood stimulation program
13. Perceptions of the healthcare system
14. Perceptions of the early childhood education system
15. Perceptions of the basic education system

⁸¹ These pre-investment studies are available at: <http://www.crececontigo.gob.cl/material-de-apoyo/material-para-equipos-chile-crece-contigo/archivo-historico>

3.3.2 Ongoing Evaluation and Monitoring

The design and implementation of a plan for ongoing evaluation is key to systemic management, lending transparency to public policy and providing the feedback required to make informed decisions about potential adjustments. It also drives the continuous updating of a nationwide system of coverage, which, to be and remain effective, must respond to the changing needs of the target population. It must include tools designed to evaluate specific and complementary methodological features, combining quantitative and qualitative methods depending on what is being assessed. While it must focus on assessing results and impacts, it must also assess implementation processes and constantly monitor management. It must therefore provide useful short-, medium-, and long-term information for the management of the public policy, allow for the follow-up of progress and outcomes in system implementation, and facilitate integrated analysis of its implementation and performance. To this end, evidence from independent studies and assessments must be combined with information generated by continuous monitoring, using management tools and administrative information as sources of data with which to foster informed decision-making based on appropriate analysis.

In ChCC, the combination of assessments carried out⁸² together with continuous monitoring performed using the various tools and instruments (Box 12) have fostered decision-making in a constantly improving model (a description of which is provided below). However, as the national ChCC team cautions, analyzing the results of multiple assessments requires a holistic view in accordance with the design of the system itself. However, the data generated by these assessments must not be viewed in isolation. Rather, it needs to be interpreted over time, taking into consideration the various contexts and divergent levels of local development in which Chile Grows with You operates.⁸³

The information provided by these sources not only contributes to decision-making at a macro level but also constitutes an important tool for feeding local management with content and guiding the support from supporting regional and provincial institutions required by ChCC municipal networks. To this end, the national level provides reporting instruments for the intermediate and local levels that allow them to: i) optimize their own decision-making; ii) adopt a broad view of the management of municipal network processes, creating the possibility of ultimately improving child development indicators; iii) quantify the performances of the municipal networks over time as each report provides information on relative performances (relative to other networks in the country) and absolute performances in such a way as to check

⁸² For more details, see the Program Files section.

⁸³ Government of Chile. (2011).

managerial outcomes in the short term; iv) Identify managerial gaps and challenges in areas that could be improved by each network; and v) steer areas of technical assistance from the regional and provincial levels toward the municipal networks (Box 13).

Box 12. Ongoing Monitoring of Chile Grows with You

To continuously monitor its programs, the Chile Grows with You (ChCC) initiative draws on information from a variety of tools and instruments. These include:

Chile Grows with You Registration, Referral, and Monitoring System (SRDM): An online platform managed by the Ministry of Social Development (MDS) providing traceability for the cross-sectoral management of cases. This helps generate alerts concerning at-risk situations, thus enabling the timely activation of services, records and monitors the implementation of agreed actions, and supports the local management of the network.⁸⁴ (For more details, see Program Files section.)

Agreement Management System (SIGEC): An IT platform managed by the Ministry of Social Development (MDS), enabling the monitoring and administrative follow-up of the transfer of resources to local governments and management.

Department of Health Statistics and Information (DEIS) of the Ministry of Health (MINSAL): Manages, stores, generates, and analyses data from the population receiving regular health checks using indicators determined by each program.

Periodic population surveys: Main surveys include the National Socioeconomic Classification Survey (CASEN), the Longitudinal Early Childhood Survey (ELPI), the Quality of Life Survey (ENCAVI), and the National Health Survey (ENS).

Having information management and monitoring tools that maintain individualized records for each beneficiary facilitates the cross-referencing of data, enriches analytical possibilities, and enables the construction of tools for the design, implementation, monitoring, and evaluation of more complex policies. The **Integrated System for Social Information and Local Disaggregation (SIIS-T)**, also managed by MDS, is a good example of this capacity. This system provides locally disaggregated indicators of individuals, households, and their surroundings based on a range of available data sources, such as the **Social Household Registry**. This registry contains a database integrating information contributed by households and State administrative records for those assigned to the registry.⁸⁵

⁸⁴ Government of Chile. (2011).

⁸⁵ For more information, see: <http://www.ministeriodesarrollosocial.gob.cl/informacion-social>

Box 13. Management Reports for Community Performance Indicators

Optimizing local management requires the creation of measurable cross-sectoral standards that reflect the effective functioning of local networks from implementation of activities to final results, thus facilitating a general overview and assessing the evolution of cross-sectoral management. This in turn enables the identification of gaps and challenges, which can help guide technical assistance from the national, regional, and provincial levels to the local level. Since 2008, Chile Grows with You (ChCC) has issued management reports, which have been perfected and modified over the years and provide feedback at the local, sub-national, and national levels on the work of local networks. All of these extract and integrate key information from the monitoring systems (see Box 12), including descriptions of supply and demand for services, user access to benefits, and the management of risk indicators for children.

Management Reports (INFOGEST): Issued from 2008 to 2013, these reports delivered feedback on the pregnant women and children served as well as general statistical data on the use of specific programs. The reports were generated manually every 3 months based mainly on data from ChCC's Registration, Referral, and Monitoring System (SRDM) as well as statistics from the Ministry of Health's Department of Health Statistics and Information (DEIS).

Chile Grows with You Key Performance Indicators (KPI): Implemented from 2014 to 2016, feedback was focused more directly on administrative management indicators, programs, and outcomes from local networks, expanding the base of their data sources and determining weightings for each element being considered in order to set performance categories for each municipal network. They incorporated elements that included percentage of budget execution, percentage of referrals associated with alerts of at-risk situations and their resolution, the recovery rate of children with developmental lags served by the program, and the monitoring of alert indicators associated with the services offered through the Biopsychosocial Development Support Program (PADB).

Key Performance Indicators (KPI): Used from 2017 to the present, these indicators are calculated quarterly and are based on a selection of the most relevant metrics reflecting the level of functionality of ChCC's municipal networks, including: (i) percentage of profiles included in the SRDM; (ii) use, registration, and timeliness of the SRDM; (iii) successful resolution of alerts in the SRDM; and iv) recovery rate of children who graduated from the Child Development Support Program (MADI) and that of children with normal psychomotor development. Municipalities are classified into four performance categories (low, medium low, medium high, high) based on municipal quartiles according to the distribution observed in the data, ranked from lowest to highest performance.⁸⁶

Beyond the accumulation of data, the challenge for information and knowledge management is facilitating the administration and analysis of such data. The network of parties involved must learn to select and observe differences, similarities, and patterns in order to support and promote decisions that ultimately favor comprehensive child development. Directives are therefore given to local teams through the Technical Guidelines for the Management of Chile Grows with You Networks instrument.⁸⁷

⁸⁶ Ministry of Social Development. (2017e).

⁸⁷ Document available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2016/04/OT-Redes-VF.pdf>

3.4 Improving the Institutional Framework

Under another guiding principle in the design of the ChCC system, existing institutional infrastructure was used as a base, reorganized and, gradually improved with a view to comprehensive management. This required the identification of institutional, administrative, and legal obstacles as well as opportunities in order to develop the most effective instruments and institutions along with a plan designed to achieve short- to medium-term progress in overcoming barriers and ensure proper system implementation.

Although ChCC had the necessary political primacy and could count on the buy-in of management teams in carrying out the task at hand, it also harnessed specific institutional experience and strengths. For instance, it drew on the experience of the Ministry of Planning (MIDEPLAN, which became the Ministry of Social Development in 2011) in the design of integrated intervention strategies, cross-sectoral coordination among participating institutions, and technical support and assistance to implementing municipalities.⁸⁸ It also drew on the strengths of the Ministry of Health (MINSAL), not only as the actor with which children and their families usually have contact during their early years but also because of its vast experience in the effective and efficient implementation of universal strategies based on national directives.

In a report entitled *The Future of Children is Today*, the Presidential Advisory Council on Early Childhood Policy (Box 1) issued a series of recommendations on the institutional and legal improvements required if the setting up of a system of this size and complexity is to succeed.⁸⁹ Gradually, both the institutional and legal frameworks governing ChCC benefits and services were improved, giving greater strength to the model and consolidating it as a stable government policy at times of changing political leadership in the country (Figure 11). What initially arose from a strong commitment on the part of the highest authorities in the government began to acquire legal backing, thus formalizing and institutionalizing political commitments. Law No. 20.379 of 2009, which created the Inter-sectoral Social Protection System and institutionalized *Chile Grows with You*, recognized its services as rights and the accompanying regulations operationalizing them as explicit guarantees.

In addition, a legislative agenda drawing on the recommendations of the Presidential Advisory Council and prior specialist analysis was drawn up and is driven by the understanding that Chilean

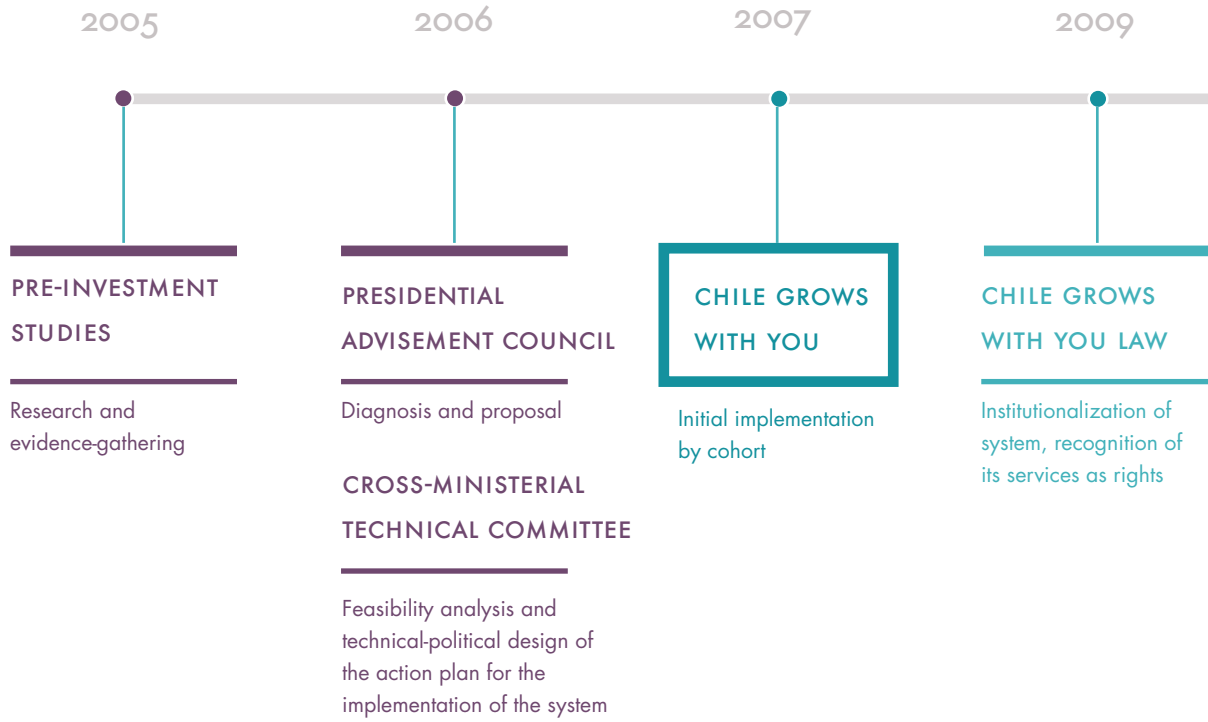
⁸⁸ Since 2002, MIDEPLAN has implemented the *Chile Solidario* Social Protection System, which is aimed at families in a situation of extreme poverty based on a model of inter-sectoral service provision at the local level in favor of the system's beneficiary households.

⁸⁹ Presidential Advisory Council on Early Childhood Policy. (2006).

legislation required improvements if it was to assist children in the process of bonding from birth to their significant adult figures (especially mothers and fathers) (Box 14).

FIGURE 11

Milestones in the Construction and Consolidation of Chile Grows with You



2016

BEGINNING OF
GRADUAL EXTENSION
OF CHILE GROWS WITH
YOU TO AGE 9

Expansion of system

2018

REGULATIONS FOR
CHILE GROWS
WITH YOU LAW

Fine-tuning of
institutional structure

OFFICE OF THE
UNDER-SECRETARY
FOR CHILDREN

ADVOCATE FOR
THE RIGHTS OF
CHILDREN

DRAFT LEGISLATION
UNDER DISCUSSION

Comprehensive system
for the protection of
children's rights



Box 14. Legal Reforms Promoted within the Chile Grows with You Framework

The analysis issued by the Presidential Advisory Council and its subsequent evaluation by the Cross-Sectoral Technical Committee enabled the elaboration of a series of legal amendments, including the following highlights:

1. Support for the bill, at that time pending in Congress, which permitted the automatic transfer of unused days of prenatal leave to the postnatal period in the case of premature birth;
2. Support for the bill aimed at modifying the current norm granting women the right to transfer up to the first three weeks of prenatal leave and subsidy to the postnatal period, fulfilling requirements to protect the health of both mother and child;
3. Fine-tune legislation protecting adopted children by: a) setting a deadline of no more than 2 months for a child to be declared eligible for adoption; b) ensuring the right to postnatal leave and subsidy for adoptive mothers and fathers regardless of the age of the child adopted; and c) ensuring the right to postnatal benefits starting as soon as the parents begin taking care of the child rather than as of the definitive adoption ruling;
4. Promote a project guaranteeing the right of working mothers to breastfeed their children regardless of whether or not the worker has the benefit of a nursery;
5. Extend the right to a subsidy and leave due to the serious illness of a child under 1 to parents of children with disabilities that, although not serious, alter their normal development;
6. Set the Family Subsidy, from pregnancy to age 18, as automatic for children whose parents belong to the 40% most vulnerable households in the country.

Below are excerpts of the main laws,⁹⁰ in order of publication, which have been enacted in connection with the legal amendments fostered by Chile Grows with You (ChCC).

1. **Law no. 20.166 of February 12, 2007, granting the right of working mothers to feed their children under 2.** Working mothers are entitled to at least 1 hour a day to feed their children under 2. This right may be applied in one of the following ways, to be agreed upon with the employer:
 - a) At any time during the work day;
 - b) Divided, at the request of the working mother, into two portions;
 - c) Delayed or brought forward by half an hour or 1 hour at the beginning or end of the work day.

This right may be exercised, preferably in a nursery or wherever the child may be. For all legal purposes, the time used will be considered hours worked. The right to feed one's children cannot be renounced in any way and is applicable to all female employees with children under 2, even if they do not have access to a nursery.

2. **Law no. 20.203 of August 3, 2007, amending norms related to the family subsidy and adoption.** The law that modifies norms related to the family subsidy and adoption, eliminating set quotas, and establishing provisions enabling automatic access to this social service, especially for pregnant women and children. The following are excerpts of the legal modifications:

Amendment to Law no. 19.620 related to adoption. The legal declaration that the child is eligible for adoption will proceed, whether or not the child's filiation has been determined, when the father, mother, or persons to whom the child's care has been entrusted does not provide the child with personal or economic care for a period of two months. If the minor is under one year of age, this period will be 30 days (among other situations already defined under this law).

⁹⁰ These excerpts are taken from the Library of the National Congress of Chile, available at: <https://www.leychile.cl/Consulta/homebasico>, and from the website of the Department of Labor of the Government of Chile, available at: <http://www.dt.gob.cl/portal/1626/w3-channel.html>

Amendment to Law no. 18.611 related to the Family Subsidy (Article 3). Family subsidies available to persons lacking resources in compliance with the norms set by Law no. 18.020 shall be granted by municipalities to dependents and beneficiaries who meet the requisites set by said legal body in accordance with the procedure established by the regulations of the Ministry of Labor and Social Welfare, conditional on approval by the Ministers of Finance and Planning. Beneficiaries must have received a score equal to or less than that set by said regulation on the evaluation of their socioeconomic situation in accordance with the instructions issued by the Department of Social Security.

Amendment to Law no. 18.020 related to the Family Subsidy (Article 3). Pregnant women who meet the requirements prescribed herein shall be entitled to the subsidy established by this law.

3. **Law no. 20.535 of October 3, 2011. This law stipulates equal rights to be absent from work for mothers and fathers of children with disabilities.** This law gives mothers and fathers the same rights and mechanisms for restitution with respect to absences from work when the health of their child over 1 and under 18 requires personal care in the event of a serious accident or a serious, acute, or life-threatening illness (Article 199 of the Labor Code). This applies to parents of children with disabilities registered in the National Disability Registry or, in the case of children under 6, with the diagnostic determination of the attending physician.
4. **Law no. 20.545 of October 17, 2011, introducing amendments to norms on maternity protection.**
 - **Amendments to maternity leave**
 - **Leave for the birth of a child.** The new provision introduces an improvement to the birth leave benefit since it may now be granted to fathers who are in the process of adoption, whereas the previous norm only granted leave to fathers once the adoption had been finalized and was only available once the court decision had been made. The new provision is applicable to fathers who have begun the adoption process and enables them to access this leave once they receive notification of the resolution granting them care of the minor.
 - **Postnatal leave or remainder thereof in case of the death of the mother.** In the case of the death of the mother, where the father does not have custody of the child, the person granted custody of the minor is incorporated as the beneficiary of the postnatal leave or the remainder of such leave, and, in addition, is granted the protection established in Article 201 of the Labor Code, including entitlement to the subsidy, which will be equivalent to total salary earned and allowances received.
 - **Employment or job retention.** To ensure the best application of the norms on maternity protection, notwithstanding any stipulation to the contrary, this amendment stipulates that the jobs of pregnant and puerperal women must be retained for them during leave, including postnatal parental leave.
 - **Amendments related to premature and multiple births**
 - **Increased postnatal leave in the case of premature birth.** If delivery takes place before the 33rd week of pregnancy or the child weighs less than 1,500 grams, the 12-week postnatal leave, which constitutes the general rule, is increased to 18 weeks.
 - **Increased postnatal leave in the case of multiple births.** In the case of multiple births, the postnatal leave period is increased by 7 consecutive days for each child born, starting with the second.
 - **Increased postnatal leave if the two circumstances mentioned in the previous points concur.** If the above mentioned circumstances concur, that is, in the case of a multiple birth before the 33rd week of pregnancy or if one of the babies in a multiple birth weighs

less than 1,500 grams at birth, the duration of the postnatal leave will be the longest applicable case.

- **New postnatal parental leave.** This authorizes working mothers to take time off to breastfeed and care for her child immediately following the 12-week postnatal leave. Postnatal parental leave can be used by the mother in two ways: a) 12 weeks of full leave, as a continuation of the postnatal leave and with entitlement to the subsidy; or b) 18 weeks of partial leave, returning to work part-time once postnatal leave is over. Working mothers who choose to go back to work part-time are entitled to 50% of the subsidy payment and at least 50% of the fixed stipends established in their contract, with no restrictions on other variable wages they may earn. This right applies to female employees, although if both parents work and the mother so decides, the working father may make use of the postnatal parental leave, starting from the 7th week, for the number of weeks the mother chooses, up to 12 or 18 depending on whether she opted for full or part-time leave. The weeks used by the father must be in the final period of the leave.
- **Amendment to maternal labor protection.** The new regulation retains the duration and terms of the maternal labor protection such that this right concludes 1 year after postnatal leave has expired without considering the period of postnatal parental leave. However, according to the new regulations, the father who takes advantage of the postnatal parental leave also qualifies for paternal labor protection for a period equivalent to twice the length of his leave, to be counted starting 10 days before leave begins. This protection cannot be extended beyond 3 months.
- **Irrevocability.** The rights stemming from the new regulations introduced by Law no. 20.545 are irrevocable.

5. **Law no. 20.891 of January 20, 2016, improving postnatal parental leave and access by government employees to the right to a nursery.**
6. **Law no. 21.063 of December 20, 2017, creating insurance to facilitate support for children suffering from specified illnesses and modifies the Labor Code for these purposes.** Also known as the Sanna Law, it provides compulsory insurance coverage for working parents of children with serious health conditions, to be implemented gradually. Beneficiaries are workers and temporarily unemployed persons who are parents of a child over 1 and under 15 or 18, as applicable, affected by a serious health condition. Workers granted care of a child by court ruling are also beneficiaries. Persons affiliated to this insurance scheme will be entitled to be absent from work for a given period of time and to the payment of a subsidy that totally or partially replaces their salary for the duration of the period during which that their child requires attention, support, or personal care.

3.5 Recognition of Sectoral Technical Authorities and Policy Steering Body

The Chile Grows with You (*Chile Crece Contigo* – ChCC) initiative was designed to recognize that each sector retains technical authority over the specific subjects falling within its remit as well as responsibility for providing services specific to each sectoral ministry and department involved. In effect, each actor participating in the intersectoral network retains and strengthens its areas of competence and responsibility but implements activities related to ChCC on the basis of guidelines defined in collaboration with the policy's steering body (in this case, the Ministry of Social Development and the Inter-ministerial Social Development Committee) (Figure 9). Together with their sectoral departments, the ministries are responsible for determining the standards to be achieved and for delivering services in accordance with the chosen objectives.

The appointment of a public body tasked with assuming a coordinating role is usually a policy decision related to the requirements of steering an intersectoral policy. Housing an integrated system in a sectoral ministry without specific intersectoral or intergovernmental coordination beyond its own area of specialization could pose the risk of converting the entire strategy and the associated system into just another sectoral policy competing with other sectoral priorities. The institution that takes on the coordinating role for an integrated policy must have the required administrative powers and be equipped with mechanisms to enable it to effectively exercise this steering role. Countries with similar experiences to that of Chile have elected to create super-ministries or to house the policy within their presidential cabinet in recognition of the importance of early childhood policies.

However, effective coordination is not achieved solely through the political hierarchy of the institution or authority in question. Rather, it requires legal and administrative tools if it is to ensure accountability between sectors as well as sustainability beyond the term of the current administration. In this context, the ChCC experience and the adoption of mechanisms designed to ensure agreement over budget transfers to participating sectors by the steering body are crucial (Box 15, Figure 12). This is arguably one of the critical elements behind the success of the ChCC management model because the steering and coordinating institution for the system determines the resources transferred to the provision of specific services to the target population on the basis of outcomes. This mechanism requires that the bodies implementing the services issue reports that will enable the steering body to monitor the implementation of the system and make improvements where necessary. Moreover, these intersectoral budget transfers are an effective mechanism for ensuring that resources are implemented in the specific areas to which they were allocated by giving authorities less opportunity to redirect these resources to other sectoral objectives. Experience shows that this mechanism has been highly effective in terms of institutionalizing coordination between the Ministry of Social Development (MDS) and the

Ministry of Health (MINSAL) and that it facilitates the definition of a catalog of services (with standards, responsibilities, performance indicators, and materials, among other aspects), reporting by the health sector, and effective constraints on the use of the budget for the purposes specified.

Box 15. Budgetary transfers

Budgetary transfers between State institutions are used systematically as part of the Chilean fiscal budget for cross-sectoral programs or social policies or where various State entities participate actively and take part in financing. Using this administrative mechanism, the Ministry of Social Development (MDS) increases budget lines executed by another sector (for example, the Ministry of Health), operating as a conditional transfer with specific regulations outlined in the accompanying notes appended to the Public Sector Budget Law each year and in the setting of Resource Transfer Agreements. (For more information, see Program Files section.)

Key programs such as the Biopsychosocial Development Support Program (PADB) are executed under this budgetary model, where every year, the Ministry of Social Development (MDS) transfers resources to the Ministry of Health (MINSAL), which in turn passes them on to the Health Services. The Health Services then formulate work plans based on a defined budgetary framework in order to deliver each of the benefits contained in the catalog of services (Figure 12).

When ChCC was created, budget lines directly assigned to particular sectoral institutions were increased to enable the delivery of the corresponding services. However, since these budgets were not linked to equivalent administrative and programmatic instruments, no administrative accountability mechanisms were established, making their coordination within the system more complex.

FIGURE 12

**Chile Grows with You
2017 Budget, Executed
According to the Resource
Transfer Agreement**

PROGRAM	INSTITUTION RECEIVING BUDGET TRANSFER (PROGRAM EXECUTOR)	BUDGET EXECUTED FOR 2017 (USD THOUSANDS)
<i>FONO INFANCIA</i>	Integra Foundation	153
BIOPSYCHOSOCIAL DEVELOPMENT SUPPORT PROGRAM (PADB)	Ministry of Health (MINSAL)	29,111
NEWBORN SUPPORT PROGRAM (PARN)		22,660
PRE-ELEMENTARY EDUCATION (EARLY CHILDHOOD EDUCATION EQUIVALENCY PROGRAMS)	National Early Childhood Education (JUNJI)	7,576
INTERVENTION FUND FOR CHILD DEVELOPMENT SUPPORT (FIADI)	Municipalities	4,174
COMPETITIVE DUND FOR INITIATIVES FOR CHILDREN		693
MUNICIPAL STRENGTHENING PROGRAM (PFM)		4,226

Programs forming part of the Chile Grows with You extension are not shown.

SOURCE: Budget Division (DIPRES), Ministry of Finance, Government of Chile. Adjustment factor supplied by DIPRES.

3.6 Intersectoral Management

Setting up and managing an integrated system requires the various actors involved to coordinate their activities in order to ensure the achievement of a common and shared macro-objective that is not always among the top priorities of each sector or authority. Successes and failures must also be shared, with prominence ceded in favor of shared responsibility. For this to work, standards, procedures, decision-making mechanisms, and spheres of responsibility must be clearly defined in relation to each specific component. This translates into more complex working strategies, thus promoting effective, systematic, and far-reaching interaction with other institutions that usually manage their own regulations and processes according to their own institutional culture and roadmap.

Incorporating modes of work adopting a social protection approach that considers its target population as rights holders capable of demanding the fulfilment of such rights by the State requires the implementation of benefits and services redesigned and adjusted to focus on the support needs of the population over and above institutional needs or capacities. To achieve this, simple processes must be implemented, in clear language, while promoting greater symmetry of power between user and service provider as regards the users' needs, privacy, and autonomy. When incorporated into integrated policies, these new requirements necessitate profound transformations in the processes, instruments, management flows, and organizational culture to which public institutions are accustomed. This can give rise to tensions and require periods of learning and adjustment. As a result, the introduction of a wide-ranging policy can be accompanied by resistance from the very actors called upon to implement it, who demand effective technical tools and political responses and who do not always have the resources or capacity required. Changes should therefore be introduced gradually, not (only) in terms of the services included in the system or the beneficiaries reached but also in terms enabling it to become fully operational in all sectors and locations.

The ChCC management model outlines the path to follow and constitutes a point of departure for building new integrated public policies addressing other multidimensional issues. Its effective implementation and its capacity to deliver integrated, differentiated, relevant, and timely responses varies across each location and each sector involved. It is possible to identify on-going challenges in terms of developing institutional, professional, and technical capacities, redesigning management tools, administrative and associated operational processes, and strengthening technical assistance resources to guide these changes to institutional practices, particularly at the regional and national level.

At the local level, the model is based on intersectoral coordination, which is achieved through the creation of municipal ChCC networks (Box 3). Resources are available for putting the system into operation through the Municipal Strengthening Program (PFM – formerly, the Municipal Strengthening Fund).⁹¹ However, the provision of these resources is conditional on the development of a joint work plan and enables the implementation of such a plan. Among the factors determining whether a municipal network is capable of adequate coordination and integrated management of its services, the following should be noted:⁹²

- Is its institutional leadership recognized by the various actors participating?
- Does it include concrete actions designed for working as a network, such as regular meetings, monitoring commitments, and continuous provision of information to all members about the status of users, among others?
- Does it have participative planning spaces, where all members feel that they are part of a shared objective?
- Does it create opportunities for dialogue with actors at the central and regional levels?
- Does it systematize progress and missteps on an ongoing basis?
- Does it have a culture of collaborative work and continuous learning?

Likewise, good network management considers how to effectively use the various tools at its disposal. This means that:

- a. It has full knowledge of the information provided by the Registration, Referral, and Monitoring System (SRDM) and carries out investigations, alerts, referrals, monitoring, and tracking of the various cases, as required;
- b. It manages referrals based on an up-to-date opportunity map (Box 5) that identifies the specific resources (benefits and services) for referral within the network.

Both instruments (SRDM and opportunity map) guide the development of an annual work plan for the municipal network, which enables it to address those aspects that require improvement and those needing continuous development to ensure the achievement of the actions committed to in relation to supporting children's development. This annual plan also includes the training required by the network to build its capacities in the various interrelated areas.⁹³

Case management is understood broadly as "a mechanism that aims to link and coordinate segments of a service provision system"⁹⁴ and is the ChCC networks' principal mechanism for action and information management. Through the SRDM, these networks have the information required to make decisions regarding services that positively impact children and

⁹¹ For more details, see the Program Files section.

⁹² Alcalá Consultores Asociados. (2009).

⁹³ Based on Ministry of Social Development. (2015).

⁹⁴ Sarabia, A. (2006).

their families. The objective of the case management model is to resolve the situations of risk identified by ensuring that: i) support needs are monitored and effectively resolved; ii) services are integrated and respond to the needs of the users; iii) services and provisions are delivered efficiently and in a timely manner; and iv) support for system users is available continuously.⁹⁵

Through the PFM, the Ministry of Social Development (MDS) transfers funding to the municipalities in order to contribute to the implementation of the annual intersectoral work plans drawn up by the ChCC municipal networks. This makes it possible for the institutions participating in these networks to provide information about and access to the services available and thus ensure timely and relevant support in response to the needs of each person covered by the system. With the support of these resources, the networks can fund items such as human resources, training, the development of opportunity maps, and promotional materials.

3.7 Key Management Tools

Even though this is not the ideal scenario, the introduction of the system can begin without all the management, administrative, and monitoring tools having been developed. ChCC was initially implemented using a simple online register of pregnant women (the first target group included in the system), with several of its management tools still under construction, gradually taking shape and being improved as part of a continuous improvement process. However, it is essential to recognize that the success of effective intersectoral management lies in having working tools and that it is vital to provide in the shortest time possible tools and mechanisms that provide relevant support to the actors seeking to coordinate with each other, thus facilitating the timely information sharing that is key to the achievement of the established objectives.

ChCC has 4 key management support tools:⁹⁶

1. The Registration, Referral, and Monitoring System (SRDM) – an information management tool;
2. The Municipal Strengthening Program (PFM) – an institutional strengthening tool.
3. The Resource Transfer Agreements – a budget management tool; and
4. The Competitive Fund for Childhood Initiatives – an innovation support tool.

The introduction and use of these tools relies on creating the right conditions for them to function properly, such as the allocation of staff time and the acquisition of skills for their ongoing administration and use by all actors to which they are targeted. These elements must be clearly planned and budgeted as part of the requirements for the introduction and ongoing management of the system.

⁹⁵ Ministry of Social Development. (2015).

⁹⁶ For more details, see the Program Files section.

3.8 Gradual Rollout that Respects the Integrated and Universal Nature of the System

Implementing a system with universal coverage over a relatively short time requires complex institutional, legal, and financial conditions. It is therefore essential to consider a gradual rollout that respects the principles of integration and universality underlying the design.

As regards local coverage, ChCC was introduced in two stages. The system was launched in June 2007 in 159 municipalities (out of a total of 345 across the country) through the formation of municipal ChCC networks and the launch of the Biopsychosocial Development Support Program (PADB) in health services in these locations. The remaining municipalities were incorporated in the following year. When selecting the first municipalities, those most likely to be successful were considered. This facilitated a sufficiently satisfactory and rapid introduction so as to validate the model and lay solid foundations that would enable its gradual extension with high levels of success in the short term. Thus, the experience of the first municipalities provided foresight for those that followed.

The inclusion of beneficiaries was also gradual, taking place in annual cohorts (Figure 4). In the first year, the first generation of pregnant women was included (in the first municipalities covered by the system), and the following year, the next cohort of pregnant women was included together with the newborns of those families included from the first year, and so on. By 2011, all pregnant women and children under 4 were covered by the System as standard and in a sustainable way. The introduction of the first components of the central program (PADB) and the construction of the various support tools also progressed through the lifecycle as the first cohorts grew older. In the first year, efforts mainly focused on those services aimed at pregnant women and providing support during birth. Gradually, activities were introduced aimed at directly supporting children in line with their age. It should be noted that any service introduced for a specific group of beneficiaries was automatically offered to the whole population for which it was designed regardless of whether the end-user was a member of the cohorts joining the system. For example, if a sensory room was introduced, this would automatically be used to support the entire population of children identified as showing developmental lags or deficits on the basis of the guarantees offered by ChCC regardless of whether the child was part of the SRDM administratively-speaking as a population covered by the ChCC initiative.

3.9 Financially Sustainable Implementation over Time

Sustainable funding over time is a key requirement for the introduction of a successful systematic strategy set up as a long-term management model (Figure 13). This is why all components included in the system must be consistent with the funding that can be guaranteed over time, which must be sustainable and able to be included in budget instruments.

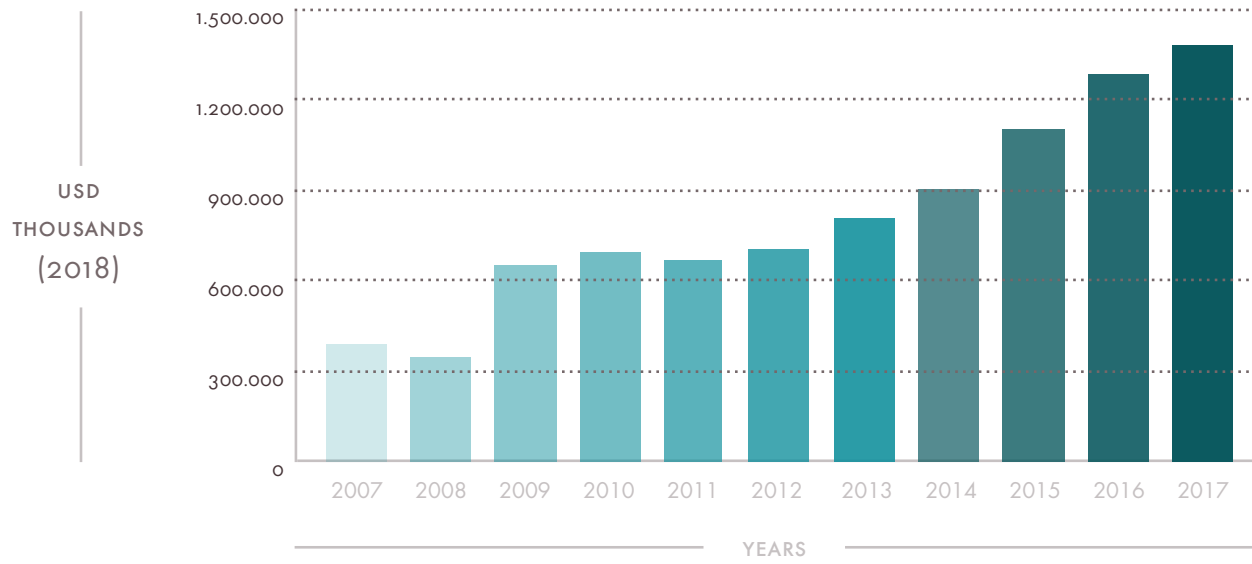
A fundamental aspect of the process of introducing ChCC was the inclusion (within the budget line for the Ministry of Planning, now the Ministry of Social Development) of a program exclusively dedicated to the Childhood Protection System (Line 21, Chapter 1, Program 6), which includes budget notes with legal force. These must be fulfilled and therefore complement the body of legislation ensuring the correct budgetary and administrative implementation of the system.⁹⁷

Under the same budget line, the budget of the system's central program (PADB), the Newborn Support Program (PARN), and the note on the introduction of equivalent methods into the early education system of the National Council of Nursery Schools is reflected in the laws governing both the steering ministry and the implementing ministry (Ministries of Health and Education, respectively) through a consolidated transfer figure. This requires both institutions to report to the National Congress annually on the implementation of these resources. Furthermore, some resources must be reported to the National Congress only by the Ministry of Social Development (MDS) as they are considered part of transfers to other public bodies (Subheading 24, Item 3). These budget items facilitate the alignment of institutions with the management of the system in terms of their multi- and intra-sectoral activities.

⁹⁷ For example, the Ministry of Social Development's Budget Law for 2018 can be found at: http://www.dipres.gob.cl/597/articles-168658_doc_pdf.pdf

FIGURE 13

Chile Grows with You budget execution 2007-2017



SOURCE: Budget Division (DIPRES), Ministry of Finance,
Government of Chile. Adjustment factor supplied by DIPRES.

3.10 A Dynamic and Continuously Improving System

ChCC is based on gradual introduction that continues to be adjusted and improved as it moves forward and extends its reach in response to new contexts. To achieve this, as with its design, it uses the evidence and data available.

Changes and adjustments to its programs over the years are visible, for example, in the innovations incorporated into the toolbox delivered to caregivers and the educational workshops conducted as part of the Newborn Support Program (PARN), which saw improvements following the findings of studies conducted in 2011 and 2014.⁹⁸ Likewise, a 2009 study entitled Quantitative and Qualitative Analysis of the Chile Grows with You Municipal Networks⁹⁹ guided improvements to the Municipal Strengthening Program (PFM) as well as the extension of its budget, and the study entitled Implementation and Outcomes of the Child Development Support Program Implemented through the Intervention Fund for Child Development Support (FIADI)¹⁰⁰ served as a key input for the development of the technical guidelines for the Child Development Support Program.¹⁰¹

Moreover, the ChCC system develops methodologies designed to process information and monitor expected outcomes by continuously feeding content into its management structures. This guides, for example, the periodic updates to the catalog of services as well as the creation of new services and indicators, which maximizes the use of administrative data available to inform decisions related to the operation and outcomes of the system.

Furthermore, ChCC has a specific tool for innovation, namely the Competitive Fund for Childhood Initiatives,¹⁰² which funds the development of various initiatives within the system. Some examples of innovations developed through this tool are: i) music composition and writing competitions for children, with resulting materials made available to users of the system through its programs; ii) introduction of recreational and educational equipment in children's hospital wards through the Playcart and Playchest initiative; iii) implementation of a reading program with the introduction of libraries in nursery schools and daycare centers through the Born to Read initiative; iv) piloting intervention strategies for promoting bonding in hospitals; and v) trial implementation of strategies aiming to designate public spaces for childhood and parenting, through the Public Space Designation for Childhood (HEPI, for its acronym in Spanish) and HEPI-Parenting programs.

Other elements developed over the years as part of the continuous improvement process include:

⁹⁸ For more details, see the Program Files section.

⁹⁹ Alcalá Consultores Asociados. (2009).

¹⁰⁰ Alberto Hurtado University. (2009).

¹⁰¹ Ministry of Social Development. (2015).

¹⁰² For more details, see the Program Files section.

- Emergency kit and the technical guidelines for healthcare and early education teams and ChCC networks designed to provide psychosocial support in emergency and disaster situations to families with children aged 0 to 5.¹⁰³ These materials emerged in response to the earthquake and tsunami that affected a major part of the country in 2010. Later, in recognition of the fact that Chile is repeatedly exposed to a range of natural disasters, the intersectoral work was improved and extended with the development of a support model for children and their families in emergency situations;
- Content, materials, and strategies related to the promotion of active fatherhood developed under the auspices of the study of the participation of fathers, mothers, and caregivers in the public health system in Chile.¹⁰⁴ Consequently, guidelines were developed for health and early education workers, a communication campaign entitled Get Involved was conducted, and educational materials aimed directly at fathers were developed;
- Educational and promotional content of the Educational Program¹⁰⁵ that from 2010 gradually adopted an approach of promoting respectful and positive parenting. This involved revising all the educational materials and technical guidelines and improving their recommendations to bring them into line with the adoption of this approach;
- Web portal www.crececontigo.cl, which was retained as one of the universal services provided by the system and has been the subject of various continuous improvements in terms of the continuous updating of the content and portal redesign (there have been 3 versions to date).

Thus, the ChCC initiative should be understood as a flexible system that involves dialogue, learning, and responding to the context while influencing and advocating the development of actions that permeate other social protection policies as well as policies designed for the protection and support of childhood.

¹⁰³ Government of Chile. (2015).

¹⁰⁴ Aguayo, F., Kimelman, E., and Correa, P. (2012).

¹⁰⁵ For more detail see the Program Files section.

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V. Program Files

5.1 Description of Programs Delivering Basic Social Services and Incorporating the Chile Grows With You (Chile Crece Contigo) Design

5.1.1 Legal registration of a birth and allocation of a Unique National Identification Number (*Rol Único Nacional – RUN*)

Population: All live newborns in Chile.

Objective(s): Legitimizing the biological existence of individuals and complete the registration of their civil status in order for them to acquire the legal status of a person, thus enabling them to exercise their rights.¹

Main features: To maintain vital records is a key element of human development planning. In Chile, obtaining this information is directly linked to the legal recognition of a person from the moment of birth through to certification. This certification has legal force for subjects and their families and legitimizes the biological existence of individuals, allowing for the civil registration of their birth to be completed in order for them to acquire the legal status of a person, with all associated rights. Failure to register a birth constitutes an obstacle that deprives an individual of an official identity, a formally recognized name, and a nationality, all of which are basic human rights. In Chile, vital records were first published in 1909 and are currently provided by a continuous and mandatory registry of vital data (live births, fetal deaths, and deaths) produced by the Civil Registry and Identification Service (SRCEI, for its acronym in Spanish), which is part of the Ministry of Justice and Human Rights. This data is processed by the National Institute of Statistics and the Ministry of Health. The variables to be included are agreed jointly by the three institutions.²

Intervention strategy: Certification of a birth, which records the biological relationship between mother and child, is completed following a birth by filling in the form Proof of Live Birth Delivery (CAPNV, for its acronym in Spanish), a public instrument regulated by law since it contains sensitive information. This procedure is carried out by the professional responsible for the delivery, who must also sign the form. The above procedure is carried out for births both within and outside of a healthcare facility. In the latter case, given that there are no biological signs that guarantee the mother-child relationship, civil registration of the newborn is carried out by means of witnesses in accordance with procedures established by SRCEI.³

¹ Ministry of Health. (2013). *Norma 160 Registro Comprobante de Atención de Parto con Recién Nacido(a) Vivo(a)*. Available at: <http://www.deis.cl/wp-content/uploads/2013/12/Norma-160-registro-CAPNV.pdf><http://www.deis.cl/wp-content/uploads/2013/12/Norma-160-registro-CAPNV.pdf>

² Ibid.

³ Ibid.

To complete the form, the healthcare professional must confirm the mother's identity using her unique national identity document and record its number (RUN, for its acronym in Spanish). In the case of foreign mothers, this procedure can be completed using her passport or the national identity document issued by her country of origin. In the event that she has no identity document, the mother's names are recorded and her fingerprint is provided on the form. Other variables are then recorded, identifying the vital event (time and date, location, and any other information relevant to the health sector), as is the medical history of the newborn and his or her parents.⁴

Once it has been completed, the CAPNV is given to the mother in order for her to request the civil registration of her child within 30 days following the birth. This procedure can be carried out by the mother, the father, or a third person (with the permission of one of the parents) by presenting the form at a SRCel office along with the identity documents of the declarant and the mother. As regards paternity, when the parents are not married, the father must recognize the child at the time of civil registration or later by public instrument, last will and testament, or any other authorized instrument. The child being registered is not required to be present. Once the registration is complete, a birth certificate is issued and a RUN is allocated. This number will be the child's unique national identity document whenever requested.⁵

Quality assurance mechanisms: SRCel is required to collect identifying information along with socio-demographic and health-related data regarding all vital events registered at its offices.⁶ Quality monitoring and validation of all statistical content of the registries of births is the responsibility of the National Institute of Statistics and the Ministry of Health, using jointly designed automated procedures.⁷ In 2013, the Ministry of Health, through the Department of Statistics and Health Information, made the National Perinatal Information System available to maternity units. This system aims to develop a repository of maternal and perinatal information and to make the records directly available at maternity units to the healthcare professionals responsible for deliveries. The aim is to reduce transcription errors in an effort to modernize and improve the quality of the statistics generated. Details of the validation activities carried out by these institutions can be found in the Yearbook of Vital

⁴ Ibid.

⁵ Civil Registry and Identification Service Website: <https://registrocivilwp.srcei.cl/tramites/inscripcion-de-nacimiento/>

⁶ Ministry of Health, National Institute of Statistics and Civil Registry and Identification Service. (2012). *Decreto No 68-12 Convenio de colaboración interinstitucional Elaboración de las Estadísticas Vitales del País*. Available at: http://www.deis.cl/wp-content/uploads/2013/06/Nuevo_convenio_Tripartito_abril_2013.pdf

⁷ Ibid.

Records issued by the National Institute of Statistics.⁸

Implementing institution or direct service providers: The Ministry of Health issues the proof of live birth delivery form, and the Ministry of Justice and Human Rights, through SRCel, formalizes the civil registration of the child, issues the birth certificate, allocates a RUN, and issues the unique national identity document.

Cost: Registration of a birth with SRCel is free. A copy of the birth certificate is free for registering with educational institutions or requesting family benefits. For any other purpose, it costs approximately USD 1.⁹

Evaluation studies

Brito, S., Corbacho, A., & Osorio, R. (2013). *El registro de nacimientos: La llave para la inclusión social en América Latina y el Caribe*. Inter-American Development Bank. Available at: <https://publications.iadb.org/bitstream/handle/11319/3567/IFD%20registro%20de%20nacimiento%20SPA%205-24-13final%20web%20.pdf?sequence=4>

National Institute of Statistics, Civil Registry and Identification Service, Ministry of Health. (2017). *Anuario de Estadísticas Vitales 2015*. Available at: <http://www.ine.cl/estadisticas/demograficas-y-vitales>

⁸ National Institute of Statistics, Civil Registry and Identification Service, Ministry of Health. (2017). *Anuario de Estadísticas Vitales 2015*. Available at: <http://www.ine.cl/estadisticas/demograficas-y-vitales>

⁹ Civil Registry and Identification Service website: https://www.registrocivil.cl/f_precios.html

5.1.2 National Immunization Program (Programa Nacional de Inmunización - PNI)

Population: All boys and girls, from pre-natal to approximately 14 years of age, in accordance with the annual schedule established by the Ministry of Health.

Objective(s): To protect the population against vaccine-preventable diseases with a significant impact on public health.

Main features: The history of vaccination in Chile began in 1765 during a smallpox epidemic, when over 5,000 individuals were inoculated with pus from cowpox sores. Following the discovery of a vaccine against this disease, the first vaccination was carried out in 1805. Then, in 1887, the Law on Compulsory Vaccination and the General Decree on Public Health were passed, creating a committee charged with advising the government in this area. A tuberculosis vaccine was introduced later (BCG, 1949). Throughout its history, this program has been supported by the organization of healthcare with a broad operational base, in particular since 1952, thanks to the creation of the National Health Service.¹ Several years later, the Extended Immunization Program was set up in 1978 in line with the 1974 recommendation of the World Assembly of the World Health Organization (WHO), with the aim of making immunization programs, which were already an integral part of public health actions, systematic. This program covered vaccines against tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles, all of which are considered lethal to young children. In addition, regulations on the mandatory and free nature of vaccinations were finalized, making immunization a right of the population.²

This led to a fall in the morbidity and mortality linked to vaccine-preventable diseases, thus contributing to an overall drop in infant mortality.

Intervention strategy: The National Immunization Program is universal and delivered through public primary healthcare facilities and private vaccination centers under an agreement with the Ministry of Health as authorized by current healthcare regulations. Vaccinations covered by the program are free, mandatory, and governed by a Ministry of Health decree, which is updated in line with epidemiological strategies and the availability of effective immunization procedures.³ The vaccinations covered by the program in 2018 are outlined in the table below.

¹ Ministry of Health website: <http://vacunas.minsal.cl/conozcanos/historia>

² Ibid.

³ Ministry of Health. (2010). *Norma general técnica sobre procedimientos operativos estandarizados para asegurar la calidad en la ejecución del Programa Nacional de Inmunizaciones*. Available at: <http://vacunas.minsal.cl/wp-content/uploads/2014/03/Res.Exenta-Nº-973-Norma-Gral.-procedimientos-POE-Completa.pdf>

Vaccination Schedule for 2018 – Ministry of Health, Chile		
Age	Vaccine	Protects against
From 28 th week of pregnancy	dTp (acellular)	Diphtheria, tetanus, whooping cough
Newborn	BCG	Invasive diseases caused by <i>M. tuberculosis</i>
2 and 4 months	Hexavalent	Hepatitis B Diphtheria, tetanus, whooping cough Invasive diseases caused by Type B <i>H. influenzae</i> (HIB) Poliomyelitis
	Combined pneumococcal	Invasive diseases caused by <i>S. pneumoniae</i>
6 months	Pentavalent	Hepatitis B Diphtheria, tetanus, whooping cough Invasive diseases caused by Type B <i>H. influenzae</i> (HIB)
	Oral polio	Poliomyelitis
	Combined pneumococcal (only premature infants)	Invasive diseases caused by <i>S. pneumoniae</i>
12 months	MMR	Measles, mumps, rubella
	Combined meningococcal	Invasive diseases caused by <i>N. meningitidis</i>
	Combined pneumococcal	Invasive diseases caused by <i>S. pneumoniae</i>
18 months	Pentavalent	Hepatitis B Diphtheria, tetanus, whooping cough Invasive diseases caused by Type B <i>H. influenzae</i> (HIB)
	Oral polio	Poliomyelitis
	Hepatitis A	Hepatitis A
School vaccinations		
Elementary 1 (6–7 years)	MMR	Measles, mumps, and rubella
	dTp (acellular)	Diphtheria, tetanus, whooping cough
Elementary 4 (9–10 years)	HPV (first dose)	Infections caused by human papillomavirus
Elementary 5 (10–11 years)	HPV (first dose)	Infections caused by human papillomavirus
Elementary 8 (13–14 years)	dTp (acellular)	Diphtheria, tetanus, whooping cough

Quality assurance mechanisms: The program has general technical standards for standardized operational procedures to ensure the quality of implementation governing the scheduling of annual requirements, receipt and distribution of program products, evaluation of contra-indications and preventive measures, prevention, observation, and management of immediate adverse events, and handling and administration of vaccines and related documentation, among other aspects.⁴

⁴ Ministry of Health. (2010). *Norma general técnica sobre procedimientos operativos estandarizados para asegurar la calidad en la ejecución del Programa Nacional de Inmunizaciones*. Available at: <http://vacunas.minsal.cl/wp-content/uploads/2014/03/Res.Exenta-Nº-973-Norma-Gral.-procedimientos-POE-Completa.pdf>

Implementing institution or direct service providers: Ministry of Health, through the network of public primary healthcare facilities, and private healthcare facilities under current agreement with the Ministry of Health.

Annual budget and funding source: USD 60.7 million (executed in 2017) under the Law on Public Sector Budgets, Sub-Secretariat for Public Health.⁵

Evaluation studies

Ministry of Finance, Budget Division (DIPRES). (2012). *Evaluación del Programa Nacional de Inmunizaciones*. Available at: http://www.dipres.gob.cl/597/articles-139781_informe_final.pdf

⁵ Ministry of Finance, Budget Division (DIPRES). Available at: http://www.dipres.gob.cl/597/articles-168581_doc_pdf.pdf

5.1.3 National Complementary Feeding Program (Programa Nacional de Alimentación Complementaria - PNAC)

Population: Pregnant women, breastfeeding mothers, children under 6, and under-25s with inborn metabolism defects.

Objective(s): To maintain and improve access to healthy and safe food and improve the nutritional status of pregnant women, breastfeeding mothers, children under 6, and under-25s with metabolic diseases.

Main features: Food supplies have been provided to vulnerable groups in Chile since the start of the 20th century and with greater stability since 1937, when the Law on Mandatory Workplace Insurance was passed. With the creation of the National Health Service in 1952, the provision of powdered milk was established as a measure closely linked to maternal and infant health programs. In 1987, Law No. 18.681 officially established the National Complementary Feeding Program (PNAC) as a universal benefit, independent of an individual's health insurance status (public or private). The PNAC program is dynamic and has been adapted to the country's new realities while maintaining its fundamental objective of contributing to the normal growth and development of every child from pregnancy onward. In recent years, the objective of contributing to the prevention of chronic, noncommunicable diseases with high prevalence in Chile was added to the program.¹

As part of the implementation of the Chile Grows with You (ChCC) initiative, a new milk formula known as *Purita Mamá* was introduced in 2008. This program was specially developed to complement the nutritional needs of pregnant and breastfeeding women until 6 months following the child's birth. One of the most remarkable innovations introduced by this food is that it contains long-chain Omega-3 fatty acids, which play a fundamental role in newborns' brain and retinal development. Docosahexaenoic acid (DHA) is deposited in the retina and cerebral cortex predominantly during the second half of pregnancy and in the first few months after birth. However, this process strictly depends on the mother's own consumption of DHA, and a lack of DHA cannot be reversed later in life. It is for this reason that this milk formula product was introduced as part of the program.

Intervention strategy: This is a universal program that incorporates a range of activities providing preventive and restorative nutritional support, through which food supplies are distributed to primary healthcare facilities in the public health network and those private facilities that currently have an agreement with the Ministry of Health.

¹ Information about this program can be found in Ministry of Health. (2016). *Norma técnica de los programas alimentarios*. Available at: <http://www.minsal.cl/wp-content/uploads/2015/09/2016.04.20-Norma-Técnica-Prog.-Alimentarios-aprobada-por-Jur%C3%ADdica.pdf>

The PNAC program is divided into sub-programs according to the age, nutritional status, or health of the beneficiary. During the first six months of life, breastfed babies and breastfeeding mothers receive PNAC products in line with the lactation status, calculated using a specific mathematical formula that determines the percentage of maternal milk the infant is receiving. The type and quantity of food provided are determined by this status.

The PNAC sub-programs are as follows:

1. *Basic PNAC*: Children, pregnant women, and breastfeeding mothers, with normal, overweight, or obese nutritional status.
2. *Booster PNAC*: Children under 6 at risk of malnutrition or malnourished, underweight pregnant women, and breastfeeding mothers who end their pregnancy underweight. This program can only be accessed via a professional nutritionist, and a consultation must take place as soon as the patient is referred following a routine health check-up. Referral may not be postponed, and the beneficiary of the booster program must be admitted immediately.
3. *Extremely premature PNAC*: A combination of preventive and curative health and nutritional support activities, through which milk formula is distributed according to the specific needs of children with a birth weight less than or equal to 1,500 grams or those born before the 32nd week of pregnancy, until age 1 year according to their corrected age.
4. *Inborn metabolism defects PNAC*: Preventive and curative nutritional support providing special formula products to all children, teenagers, and adults under 25 as well as pregnant women and breastfeeding mothers diagnosed as having one of the following conditions: phenylketonuria (PKU), maple syrup urine disease, propionic acidemia, methylmalonic acidemia, isovaleric acidemia, Type 1 citrullinemia, Type 1 glutaric acidemia, beta-oxidation disorders, homo-cystinuria, or Type 1 tyrosinemia.

The foods included in the PNAC program are:

Formula product	Generic name
Fortified Purita Milk	Powdered cow's milk, instant, 26% fat, fortified with vitamin C, iron, zinc, and copper. Gluten free.
Purita Mamá	Powdered food used to prepare an instant milk drink containing milk, milk solids, and cereals, fortified with vitamins, minerals, and Omega-3 fatty acids; low in sodium and fat.
Purita Cereal	Powdered food used to prepare an instant milk drink containing semi-skimmed milk and cereals. Fortified with vitamins and minerals. Reduced fat, high in calcium and vitamins C and E.
Mi Sopita	Powdered food used to prepare an instant cream soup for infants, containing cereals and legumes. Fortified with vitamins and minerals.

To receive the food supplies, up-to-date check-up and vaccination records must be presented in line with Ministry of Health regulations. If the beneficiary, or, in the case of a minor, the responsible adult has refused one or more vaccinations, it must be confirmed that the flowchart established under National Immunization Program regulations was followed (including advice and corresponding informed refusal). For children under 6 and pregnant women attending check-ups at private healthcare facilities, a special form must be submitted for the provision of PNAC products, duly issued, completed, and signed by the relevant healthcare professional.

Quality assurance mechanisms: The program includes technical standards that provide information about each of the feeding programs and sub-programs as well as the administrative procedures required to ensure the quality of implementation. Furthermore, acceptance and consumption of PNAC products is monitored, leading to adjustments to improve acceptance and consumption rates.

Implementing institution or direct service providers: Ministry of Health, through the public network of primary healthcare facilities and private healthcare facilities under current agreement with the Ministry of Health.

Annual budget and funding source: USD 59.6 million (implemented in 2017) under the Law on Public Sector Budgets, Sub-Secretariat for Public Health.²

Evaluation studies

Atalah, S. E., Vera, A. G., Rosselot, P. G., Araya, L. H., Andreu, R. R., Alviña, W. M., Araya, B. M., Vargas, P. V., Peñafiel, W. K., Barba, G. C., & Pizarro, Q. T. (2008). *Desarrollo, consumo, y aceptabilidad de una bebida láctea con DHA para embarazadas y nodrizas*. *Revista Chilena de Nutrición*, 35(4), 433–442. Available at: <https://dx.doi.org/10.4067/S0717-75182008000500006>

Contreras, M. A., Herrera, Y., Rodríguez, O. L., Pizarro, Q. T., & Atalah, S. E. (2011). *Aceptabilidad y consumo de una bebida láctea con Omega-3 en embarazadas y nodrizas del Programa Nacional de Alimentación Complementaria*. *Revista Chilena de Nutrición*, 38(3), 313–320. Available at: <https://dx.doi.org/10.4067/S0717-75182011000300007>

Treasury Budget Department (DIPRES) (2013). *Evaluación del Programa Nacional de Alimentación Complementaria*. Available at: http://www.dipres.gob.cl/597/articulos-141221_informe_final.pdf

² Ministry of Finance, Budget Division (DIPRES).

Ministry of Health and University of Chile's School of Nutrition and Dietetics. (2014). *Estudio nacional de aceptabilidad y consumo de los productos de los Programas Alimentarios del Ministerio de Salud: Mi Sopita, Purita Mamá, y Crema Años Dorados*. Available at: http://dipol.minsal.cl/wrdprss_minsal/wp-content/uploads/2015/09/2015.05.12-Informe-Final-Estudio-Aceptabilidad-Programa-Alimentario.pdf

5.1.4 General Regime Governing Explicit Health Guarantees (Régimen General de Garantías Explícitas en Salud - GES)

Population: Individuals suffering from a disease or condition included in the coverage list.

Objective(s): To protect access, financial coverage, and opportunities in relation to the treatment of a range of health problems that have been prioritized due to their high public health and social impact and for which cost-effective treatments are available.

Main features: In 2002, a healthcare reform was launched in Chile, which took shape through various laws passed between 2003 and 2005. In this context, Law No. 19.966 of 2004 created a regime governing Explicit Health Guarantees (GES), thus establishing a compulsory healthcare plan for beneficiaries of public health insurance and individuals with private health insurance. As part of its basket of services, the GES program covers diagnostic confirmation and standardized treatment for a range of health problems prioritized due to their high public health and social impact. Furthermore, it defines explicit and enforceable guarantees relating to access, quality, and financial coverage for selected therapeutic interventions to treat these conditions.

Intervention strategy: GES is an integrated healthcare program that prioritizes a set of 80 pathologies or health problems and guarantees access to timely quality treatment for all of these, accompanied by financial protection. The care provided under the GES program is exactly the same for beneficiaries of public health insurance and those attending private facilities.¹ The guarantees have been formulated as a means of protecting patients throughout the procedures or stages covered by this program, from suspected diagnosis and confirmation to treatment, follow-up, and monitoring of the pathology or health issue. These guarantees not only ensure the correct application of this procedure but are also enforceable by the service user. In the event of a failure to comply with one of these guarantees, the user is entitled to file a formal complaint to the relevant healthcare institution (public or private health insurance).

The guarantees apply when, during a medical consultation or routine check-up, a physician or healthcare professional suspects or diagnoses a pathology or health problem covered by the GES program. The professional must then notify the patient using a Certificate of Information. The date and time of notification recorded on this form establish the moment when the guarantees are activated as well as the timescale within which the relevant healthcare must be provided. For beneficiaries of public health insurance, access is only possible through primary healthcare centers in the public health network. However, there are exceptions to this rule in the following cases: (i) when the person requires emergency care due to a

¹ Information about this program can be found in National Health Fund Website <https://www.fonasa.cl/sites/fonasa/beneficiarios/coberturas/auge>

pathology or health problem covered by the GES program; (ii) when the patient is being treated at a secondary- or tertiary-level healthcare facility and during treatment the diagnosis of a pathology or health problem covered by the GES program is confirmed, or (iii) when, in the case of newborns, a congenital pathology or health problem covered by the GES program is confirmed.

Each of the 80 pathologies covered by the GES program has its own procedures and stages, which have been defined in advance. In some cases, the procedure includes diagnosis (suspected or confirmed), treatment, and follow-up, while in others, it includes only treatment and follow-up, and in others, only treatment. These procedures and stages are defined in the GES Clinical Guidelines developed by the Ministry of Health, which correspond to a range of systematically developed recommendations to help professionals and patients make decisions about the most appropriate form of healthcare.² Each pathology or condition covered has its own clinical guidelines.

Of the range of pathologies covered by the GES program, the following are of interest in relation to the Chile Grows with You initiative, given its target population:³

² Ministry of Health. (2014). *Manual metodológico: Desarrollo de guías de práctica clínica*. Available at: <http://www.bibliotecaminsal.cl/wp/wp-content/uploads/2016/04/Manual-metodologico-GPC-151014.pdf>

³ Ministry of Health. (2014). *Norma técnica para la supervisión de niños y niñas de 0 a 9 años en la Atención Primaria de Salud. National Childhood Health Program*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Norma-Tecnica-para-la-supervision-de-ninos-y-ninas-de-0-a-9-en-APS.compressed.pdf>

Beneficiary group	Pathology or health condition
Pregnant women	Integrated oral health of pregnant women
Pregnant women at risk of preterm delivery	Prevention of preterm delivery
Women in labor	Childbirth analgesia
HIV-positive pregnant women and babies born of HIV-positive pregnancies	HIV-AIDS
Premature newborns weighing under 1,500 grams or born before the 32 nd week of pregnancy	Retinopathy in preterm infants
	Sensorineural hearing loss in preterm infants
	Bronchopulmonary dysplasia in preterm infants
Newborns	Newborn respiratory distress syndrome
Newborns with suspected spinal dysraphism	Spinal dysraphism
Newborns to age 15	Cleft lip or palate
Children under 1	Luxated hip dysplasia
Children under 2	Moderate hearing loss
Children under 5	Lower respiratory tract infection
Children under 6	Integrated oral health
Children under 9	Strabismus
	Bronchial asthma
Children under 15	Operable congenital heart disease
	Cancer in children under 15
Under 15s with leukemia, lymphoma, or solid tumors	
Children over 1 and under 15	Epilepsy
Idiopathic children under 15	Juvenile arthritis
Rheumatoid: any age	
Under 25s	Surgical treatment of scoliosis
Any age, with suspected condition	Diabetes mellitus Type I
	Diabetes mellitus Type II
Any age	Hemophilia
	Terminal chronic renal failure
	Hepatitis B infection
	Hepatitis C infection
	Cystic fibrosis
	Systemic lupus erythematosus
	Pain management for advanced cancer or palliative care
	Surgical treatment of acquired and congenital cataracts
	Extensive burns
	Head trauma
	Major eye trauma
	Brain hemorrhage, side effects of ruptured aneurysm
	Dental emergencies
	Polytrauma
	Schizophrenia

Quality assurance mechanisms: The legal framework (law and regulations) stipulates that in order to develop the proposal for guarantees, studies will be conducted or existing studies will be used with the aim of defining a list of healthcare priorities, that is, the prioritized list of health issues and interventions related to their resolution (burden of diseases, needs and expectations of the population, and cost-effectiveness). The health issues covered must be prioritized according to the level of evidence relating to their outcomes in terms of survival or quality of life and in relation to national public health objectives, conditions that cause vulnerability, the existence of efficient and effective interventions, the safeguarding of the best use of resources, and the capacity of the system.

Implementing institution or direct service providers: Ministry of Health, through the network of public and private facilities.

Evaluation studies

Superintendent of Health, Chile. (2008). *Evaluación del acceso, equidad en el acceso, e impacto de la implementación del Régimen de Garantías Explícitas de Salud*. Available at: <http://www.supersalud.gob.cl/documentacion/666/w3-article-4332.html>

Erazo, Á. (2011). *La protección social en Chile. El plan AUGE: Avances y desafíos*. Economic Commission for Latin America and the Caribbean (ECLAC). Available at: <https://www.cepal.org/es/publicaciones/5218-la-proteccion-social-chile-plan-auge-avances-desafios>

Treasury Budget Department (DIPRES). (2013). *Evaluación del Bono AUGE de FONASA*. Available at: http://www.dipres.gob.cl/597/articles-139759_informe_final.pdf

5.1.5 Child Care or Nursery School for Infants under 2 and Preschool for Children Aged 2 to 4

Target: Children from 85 days to 4 years of age.

Objective(s): Delivering care and promoting the education and comprehensive development of children whose parents are working, studying, or seeking employment.

Main Characteristics: In Chile, care¹ for children under 2 is provided through nursery schools, and early childhood education for children over 2 is provided through preschools. Both types of institution are regulated under the General Education Law and integrated into the basic level of the education system or early childhood education,² though without constituting a mandatory level.³ This service is provided through private and public institutions. Private institutions are free of charge and administered by the National Early Childhood Education Board (JUNJI), an autonomous government agency associated with the Ministry of Education (MINEDUC), and by the Integra Foundation, a privately-owned non-profit institution belonging to the Foundations Network of the Sociocultural Directorate of the Presidency of the Republic.

Traditionally in Chile, child care for children under 2 has been associated with the protection of children whose mothers are working, seeking employment, or studying as well as with the protection of maternity, paternity, and family life according to the provisions of the Labor Code. In the case of women who are formally employed, Chilean legislation mandates companies or employers with 20 or more female employees (of any age or marital status) to provide adjoining and independent rooms in the workplace, where mothers can feed their infants under 2 and leave them there while working. These rooms must be either licensed or officially recognized by the Ministry of Education (MINEDUC). Employers may also fulfill this obligation by directly paying the costs of nursery school for female employees with infants under 2. In this case, the employer selects the nursery from those that have been officially

¹ For the purposes of this document, care is defined as direct attention given to an interpersonal relationship, including actions intended to promote healthy and appropriate growth, integrating aspects of nutrition and hygiene, as well as cognitive and socio-emotional stimulation. In turn, early childhood education refers to the process of teaching and learning in early childhood with an emphasis on content, the development of appropriate behaviors, skills, aptitudes, and healthy integration. However, scientific evidence indicates that cognitive processes do not distinguish between learning itself and the social interactions through which learning is constructed. Therefore in practice, early childhood education involves care. F. Marco (2014). *Calidad del cuidado y la educación para la primera infancia en América Latina*. Economic Commission for Latin America and the Caribbean (ECLAC); EUROSOCIAL Program.

² According to Decree no. 315 of 2010 issued by Ministry of Education, institutions providing early childhood education are structured as follows: Level 1 (nurseries): children aged 0 to 2; Level 2 (mid-level): children aged 2 to 4; and Level 3 (transitional level): children aged 4 to 6.

³ General Education Law. Available at: <https://www.leychile.cl/Navegar?idNorma=1006043>.

licensed or have received government recognition. Additionally, the employer must pay the return transportation costs of children under 2 to the respective institution.⁴

Intervention Strategy: The Chile Crece Contigo (ChCC) initiative guarantees free access to early childhood educational institutions for Level 1 nursery school or equivalent and children under 2, and Level 2 preschool or equivalent for children aged 2 to 5.

To access this benefit, the mother, father or caregiver must be working, studying, or seeking employment and belong to a household ranked among in the most vulnerable 60% of the national population according to the socioeconomic classification of the Ministry of Social Development.

Nursery Schools

The availability of public nursery schools is overseen by JUNJI and the Integra Foundation. This takes place either through direct management or through transfers of funds to third parties or delegated management. Regardless of the format, all nurseries are operated in institutions with specific standards for this service and offer children comprehensive care, nutrition, education, and the promotion and protection of their rights. Nurseries are generally open 11 months of the year (March to January), Monday to Friday, 8:30 a.m. to 4:30 p.m. and, where extended hours are offered, 4:30 to 7 p.m. JUNJI also offers Bring Your Child to School (PEC) nurseries for adolescent mothers and fathers attending public secondary schools to encourage them to remain in the education system. In light of this objective, they offer a comprehensive education service for children under 2 in the same school where their mother or father is studying or at a nearby location. Nurseries operate Monday to Friday and are adapted to the daily schedule of the secondary school. This includes the ability to welcome infants before the school day begins.⁵

The Integra Foundation also has nursery schools in penal institutions, with a non-conventional format⁶ and offering care, education, and stimulation to children under 2, who are able to stay with their mother during her incarceration. The children are provided with a developmentally appropriate educational program and a diet designed to encourage healthy growth.⁷

⁴ Article 203 of the Labor Code.

⁵ Information about this program can be found in National Early Childhood Education Board (JUNJI) Website: <http://www.junji.cl/educacion-parvularia>

⁶ Equivalent or non-conventional formats are educational proposals with a curricular development designed for integration into different settings and educational spaces in response to the particular characteristics of the groups involved.

⁷ Information about this program can be found in Integra Foundation Website: <http://www.integra.cl/nuestros-jardines-infantiles/modalidades-no-convencionales>

Preschools

The public availability of preschools is overseen by JUNJI and the Integra Foundation and is generally organized according to two formats:

1. Traditional preschools operating in institutions with specific standards for this service, with an educational program and dedicated staff, usually consisting of a technical-professional team, including preschool educators, child care technicians, and assistants. The ratio of professionals per child depends on the educational level. Preschools are generally open 11 months of the year (March to January), Monday to Friday, 8:30 a.m. to 4:30 p.m., and, where extended hours are offered, 4:30 to 7 p.m.
2. The alternative educational care program,⁸ with equivalent or non-conventional format,⁹ consists of an on-site program for children aged 2 to 6. This includes the active participation of the family and community through educational proposals that integrate a variety of environments and spaces and attempt to respond to the particular characteristics of the groups involved. The formats available are as follows:¹⁰
 - *Family preschool*: A pedagogical proposal incorporating the active participation of family members, developed and implemented by an education technician and the children's families.
 - *Preschool for working mothers*: Designed to meet the needs of children of working mothers, with extended hours and meals.
 - *Indigenous communities*: Administered by JUNJI with the ongoing support of indigenous families and leaders, it is based on a semi-structured intercultural curriculum that respects the community context. Children are encouraged to participate actively in culturally relevant activities such as festivities, handicrafts, and traditions, among others. The family and the community are invited to incorporate cultural contributions into the educational management and practice.
 - *Childhood Improvement Program (PMI)*: A municipal educational program in which social organizations design and present projects to JUNJI, funded through an agreement with the Ministry of Social Development. The program includes a series of documents or supporting guidelines designed to help users understand its purpose and objectives. Municipal organizations must present projects that bring together families and key community members or bearers of cultural knowledge, who, working as volunteers, construct, outline, and develop a proposal for children in their neighborhood, municipality, area, or region.
 - *Neighborhood Education Cultural Centers (CECI)*: An artistic and cultural pedagogical proposal for early childhood working with the municipality to encourage a child-centered approach to developing creativity. This program is delivered and administered by JUNJI with resources from the Ministry of Social Development.

⁸ Designation used by National Early Childhood Education Board (JUNJI).

⁹ Designation used by the Integra Foundation.

¹⁰ See: <http://www.junji.cl/educacion-parvularia/> and <http://www.integra.cl/nuestros-jardines-infantiles/modalidades-no-convencionales>

- *Preschool on Wheels*: This program delivers free early childhood education in difficult-to-access rural and urban areas. It program consists of 21 vehicles fully outfitted with pedagogical materials and visiting different regions to bring preschool to locations where factors such as low population density and geographical dispersion hinder the setting up of formal institutions.
- *My Preschool in the Hospital*: A program implemented in hospitals to ensure that children who have been hospitalized have access to early childhood education through games and brief educational experiences. Educators, social workers, and psychologists work to strengthen learning experiences and the comprehensive development of children along with parents, encouraging bonding and working to counteract difficulties associated with the hospitalization process.
- *Pehuenche Summer Camp*: An experience offered every year from January to April bringing together educators, Pehuenche families, and children in the Lonquimay area, in Araucania Region. Over the summer, Pehuenche community members camp in the mountains in order to gather pine nuts, animal fodder, and firewood for the winter. Every 15 days during this period, educational teams travel up to meet the children and their families in 5 areas of the Andes in order to offer educational experiences in a family and community context.
- *Vacationing in My Preschool*: This initiative offers children 12 continuous hours of play and educational activities in a recreational setting while their regular institution is closed. The objective is for children to continue developing their social skills and establishing ties with their peers and to encourage their creativity and imagination during regular vacation time. The program includes a variety of didactic materials used in workshops, outings, and recreational activities in the area. It also offers a seasonable light meal (winter or summer). It is aimed at children aged 3 months to 5 years, preferably those of working mothers.
- *Shelters and safe houses*: This initiative focuses on children who, due to situations related to health or rights violations, are staying at homes or shelters and do not have access to conventional nursery schools or preschools. Educators and educational technicians deliver care with an emphasis on play, recreation, and the promotion of rights, encouraging positive affective interactions, socio-emotional development and well-being, and the involvement of families and caregivers.

Quality Assurance Mechanisms¹¹: The Curricular Bases of Early Childhood Education¹² is the reference document defining the content and objectives of childhood education from the first months of life to the start of elementary school in accordance with a set of educational requirements designed to reflect early childhood characteristics within the context of today's society. This initiative takes into consideration social and cultural conditions and requirements and provides stage-appropriate educational tasks with a framework and meaning, recognizing that children are subjects of the law as well as the right of families to be the main educators of their children.

The document entitled "Guidelines for the Development of an Institutional Educational Project" (PEI) in Early Childhood Education Institutions"¹³ is a management tool designed to assist educational institutions, regardless of the level or programs offered, with the long-term planning of the organization and execution of initiatives and activities designed to ensure that children achieve the skills and knowledge laid out in the Curricular Bases of Early Childhood Education. It includes methodological criteria and specific objectives.

In Chile, the institutional framework governing early childhood education was recently restructured.¹⁴ Within this context, institutions at this level must meet certain requirements that guarantee quality standards while ensuring the welfare of the children who attend these centers. Therefore, all institutions in the country providing early childhood education must be licensed or have official recognition if they receive funding from the Department of Education, which is in charge of enforcing regulations and standards. The Memorandum of Regulations for Early Childhood Education Institutions¹⁵ was published in order to lay out the

¹¹ The publication of Law no. 20529 led to the creation of the School Education Quality Assurance System, consisting of the Agency for Quality in Education, the Ministry of Education, the Department of Education, and the National Board of Education.

¹² Ministry of Education. (2018). *Bases Curriculares de la Educación Parvularia*. Available at [https://parvularia.mineduc.cl/wp-content/uploads/sites/34/2018/03/Bases Curriculares Ed Parvularia 2018.pdf](https://parvularia.mineduc.cl/wp-content/uploads/sites/34/2018/03/Bases_Curriculares_Ed_Parvularia_2018.pdf)

¹³ Ministry of Education.(2017). *Orientaciones para elaborar el Proyecto Educativo Institucional (PEI) en establecimientos de educación parvularia*. Available at: <https://parvularia.mineduc.cl/wp-content/uploads/sites/34/2017/03/Orientaciones-para-Elaborar-el-Proyecto-Educativo-Institucional-en-Establecimientos-de-Educación-Parvularia.pdf>

¹⁴ On May 5, 2015, the publication of Law no. 20.832 led to the creation of the Charter for Licensing Early Childhood Education Institutions, while Law no. 20.835 created the Under-secretariat for Early Childhood Education and the Administration of Early Childhood Education. As a result, the education system at this level was completely restructured, and a new institutional framework for the sector emerged. This new regulatory scenario separates the responsibilities of service provision, oversight, and licensing previously administered by JUNJI and placed new actors in charge of these tasks. The Regional Ministerial Secretariats of Education (SEREMI) are now in charge of granting official government recognition and operating licenses. The task of supervising all institutions at this level, regardless of whether they have government recognition or an operating license, now comes under the Department of Education. This entity oversees the control of those institutions that provide early childhood education as well as consultations, requests, and general grievances concerning this educational level since March 1, 2017.

¹⁵ Department of Education. (2017). *Circular normativa para establecimientos de educación parvularia*. Available at: <https://www.supereduc.cl/wp-content/uploads/2017/05/Rex-N°-381-2017-gue-aprueba-Circular-Normativa-para-Establecimientos-de-Educación-Parvularia.pdf>

standards, which include general guidelines, basic operating requirements for personnel and pedagogical management, and rules on good practices and coexistence, with an emphasis on internal regulations and protocols. It also covers standards related to health and safety, including infrastructure, security, hygiene, and nutrition.

Implementing agency or direct service providers: National Board of Early Childhood Education and the Integra Foundation.

Annual budget and funding source: USD 1.259 million (executed in 2017), from the Public Sector Budget Law, Ministry of Education (JUNJI, Integra Foundation).¹⁶

Evaluation studies

Ministry of Finance, Budget Division (DIPRES). (2007). *Evaluación comprehensiva del gasto de la Subsecretaría de Educación (programa de educación preescolar), Junta Nacional de Jardines Infantiles y Fundación Integra*. Available at: http://www.dipres.gob.cl/597/articles-141084_informe_final.pdf

Agency for Quality in Education. (2015). *Representaciones sociales sobre la calidad y los sistemas de evaluación de la calidad en educación parvularia*. Available at: [http://archivos.agenciaeducacion.cl/Representaciones Sociales sobre Calidad Educacion Parvularia.pdf](http://archivos.agenciaeducacion.cl/Representaciones_Sociales_sobre_Calidad_Educacion_Parvularia.pdf)

Department of Education. (2017). *Percepciones y expectativas de las familias sobre la educación parvularia*. Available at: <https://www.supereduc.cl/estudios-y-estadisticas/percepciones-y-expectativas-de-las-familias-sobre-la-educacion-parvularia>

¹⁶ Ministry of Finance, Budget Division (DIPRES).

5.1.6 Family Allowance and Family Subsidy

Target: Workers, retired persons, and socioeconomically vulnerable individuals with dependents, either disabled or minors, who rely on them for financial support and care.

Objective(s): To contribute to the economic well-being of households with children, adolescents, or disabled persons.

Main Characteristics: The Family Subsidy, also known as the Unified Family Subsidy (SUF) and the Family Allowance (AF)¹ are social security programs that deliver conditional monetary grants and mainly seek to contribute to the economic well-being of households with children. Although these programs have different origins, in practice, these are complementary and mutually exclusive.² The Family Allowance is directed at households of workers, retired persons, and subsidy recipients who have children or dependents in their care and who are contributors to the retirement system. In contrast, the Family Subsidy is aimed at individuals or households in the most vulnerable 60% of the population who live with dependents (children under 18 or individuals with disabilities) and are unable to access the Family Allowance benefit because they are not workers enrolled in a retirement scheme (non-contributory social assistance program). It should be noted that both the Family Allowance and the Family Subsidy include a benefit aimed at pregnant women, known as Maternity Allowance or Maternity Subsidy, respectively.

The Family Allowance emerged as a condition of the formal employment of its beneficiaries, as determined by Law no. 7.295 of 1943, which granted the benefit to private employees, that is, to individuals in formal and dependent employment. Later came the incorporation of independent workers through Decree no. 307 of 1974. Most recently, the Department of Social Security (SUSESO) determined that the Unified Family Benefits System, which encompasses the Family Allowance, is “intended to benefit mainly retirees and subsidized workers.”³

The Family Subsidy was created through Law no. 18.020 of 1981, which specifies that the program is intended for “people of limited resources.” The SUF subsidy has since been described as a monetary transfer to benefit the children of families in situations of socioeconomic vulnerability.

¹ Information about this program can be found in Social Security Institute (IPS) and Department of Social Security (SUSESO) Websites: <http://www.ips.gob.cl> and <http://www.suseso.cl>

² The Family Subsidy is incompatible with the benefits of the Unified Family Benefits System (Family Allowance) according to Decree no. 150 of 1982 from the Ministry of Labor and Social Security. If a person is in a position to enable eligibility for both the Family Allowance and the Family Subsidy, one of the two must be selected.

³ Government of Chile, Budget Division. (2016). *Evaluación de Impacto: Subsidio Familiar y Asignación Familiar*. Available at: http://www.dipres.gob.cl/597/articles-146449_informe_final.pdf

Intervention Strategy: Eligibility to receive the Family Allowance is determined according to the members of a worker or retiree's family group⁴ or designated family dependents or charges. The beneficiaries are: i) dependent workers in the public or private sectors; ii) independent workers enrolled in a retirement plan; iii) recipients of unemployment or disability benefits; iv) retirees; v) beneficiaries of widowhood benefits; vi) government institutions in charge of orphaned, abandoned, or disabled children; and vii) persons with court-appointed minors in their care.

To qualify as a beneficiary of the Family Allowance, family dependents must be acknowledged and accredited by the competent body according to the worker's employment status, which may be a Compensation Fund, a Retirement Fund Administrator (*Administrador del Fondo de Pensiones – AFP*), or the Social Security Institute (IPS), among other entities. Once family dependents have been acknowledged, workers begin to receive benefit payments along with their salary in the case of dependent workers or through the Social Security Institute in the case of independent workers⁵ and retirees.

The Family Allowance delivers a fixed amount per dependent or legal charge, which decreases as the worker's salary increases. Values effective as of January 1, 2018 are:

Income bracket (USD) ⁶	Amount of Family Allowance per dependent or legal charge (USD)
Up to 453.93	17.77
Between 453.93 and 663.01	10.90
Between 663.02 and 1,034.07	3.45
From 1,034.08	0

⁴ Those who may enable someone to qualify for the family allowance, that is, legal dependents or charges, are as follows:

- Wife, pregnant wife, pregnant worker or spouse with a disability.
- Children of one or both spouses and adopted children under 18, unmarried, who are full-time students at State or State-recognized institutions. In the case of children over 18 but under 24, their studies must be accredited.
- Orphaned or abandoned children under the tutelage of government institutions that fulfill the same requirements as for children mentioned above.
- Disabled children of any age or children with disabilities under the tutelage of government institutions.
- Children cared for as a result of a court decision.
- Grandchildren and great-grandchildren who have been orphaned or abandoned by their father or mother and are granted benefits under the same conditions as children.
- Widowed mothers, with no age limit.
- Parents, grandparents, or other direct relatives over 65 or disabled of any age.

In the case of disability, a disability report issued by the Committee for Preventive Medicine and Disability (COMPIN) must be presented, while in situations of desertion, a social report on the conditions of the desertion is required.

⁵ In the case of independent workers, Family Allowance payments are made once per year.

⁶ Amounts presented here are based on the average value of the US dollar in May 2018.

The Family Allowance includes a benefit for pregnant women known as the Maternity Allowance, to which dependent and independent pregnant employees enrolled in the retirement system are entitled, as well as male employees whose pregnant wife is acknowledged as their dependent (family charge) and who therefore receive the Family Allowance. The Maternity Allowance can be requested from the 5th month of pregnancy. However, once the benefit is assigned, it is paid retroactively for the entire pregnancy. The amount granted depends on the beneficiary's earnings, decreasing as the beneficiary's salary increases, with the same values as for the Family Allowance. For employees who are dependents of their spouse (husbands), the allowance is paid by the employer and included in the salary. In the case of independent workers, depending on when the Maternity Allowance is requested, it is either paid through income tax returns filed once a year in May or through the Social Security Institute. To apply for the benefit, a medical certificate or proof of the 5th month of pregnancy is required. In the case of a multiple pregnancy, only one Maternity Allowance is paid.

The Family Subsidy (SUF) is a conditional monetary transfer directed at members of households in the 60% most socio-economically vulnerable segment of the population who do not have access to the Family Allowance because they are not formally employed and they (or their family group) are therefore unable to provide for the financial support and upbringing of those who qualify them for this benefit. SUF beneficiaries are mothers, fathers, guardians, or caregivers responsible for a child or anyone responsible for a disabled person (of any age). In addition, dependents, or those enabling SUF eligibility, are children under 18 and individuals with disabilities of any age who are financially dependent on the beneficiary. Mothers of children under 18 who are financially dependent are also sources of SUF eligibility. In this case, the mother is the beneficiary.

To activate the benefit, recipients must be registered with the Social Household Registry and belong to a household in the lowest 60% of income brackets and present the birth certificate of children under 18 as well as the certificate of completed child health checkups (for children under 6) or certification of full-time attendance at an educational institution (for children over 6). In cases of disability, a report issued by the Committee for Preventive Medicine and Disability (COMPIN) is required. These documents must be presented to the relevant municipality, where, once the beneficiary's status has been approved, it is registered and sent to the Social Security Institute, the institution in charge of paying the benefit. The monthly amount of the Family Subsidy is CLP 11,337 (USD 17.77) per family dependent or double in the case of disabled dependents. The SUF benefit is valid for 3 years, after which the request can be renewed. It is valid until December 31 of the year in which the dependent turns 18. Additionally, the beneficiary must present proof of the conditions mentioned above being met (especially compliance with child health checkups) annually.

As with the Family Allowance, the Family Subsidy includes a benefit aimed at pregnant women, specifically women who belong to the 60% most socioeconomically vulnerable households and who do not receive the Maternity Allowance. This benefit can be requested from the 5th month of pregnancy, and the entire pregnancy is covered. A certificate from a doctor or a midwife from the Health Services or institutions authorized to provide such services must be presented. Once the child is born and before it is 3 months old, the newborn is considered a SUF dependent only if its mother has been granted the SUF benefit for pregnant women. The child is then registered as a SUF dependent.

Implementing agency or direct service providers: Social Security Institute.

Annual budget and funding source: USD 109.8 million for Family Allowances and USD 408.1 million for Family Subsidies (executed in 2017) from the Public Sector Budget Law, Ministry of Labor and Social Security.⁷

Evaluation studies

Budget Division (DIPRES), Ministry of Finance. (2016). *Evaluación de impacto: Subsidio familiar y asignación familiar*. Available at: http://www.dipres.gob.cl/597/articles-146449_informe_final.pdf

⁷ Ministry of Finance, Budget Division (DIPRES).

5.1.7 Mechanism for the Protection of Maternity

Target: Employees in the public and private sectors and independent workers enrolled in the retirement system.

Objectives: To protect the care of newborns while ensuring time off and an income for their mothers and to enable mothers (and, to a lesser extent, fathers) to care for their child during the first months of life, thus promoting bonding and favoring healthy development.

Main Characteristics: In Chile, inalienable labor rights regulated by the Labor Code protect maternity, paternity, and family life¹.

Intervention Strategy: Each labor right aimed at the protection of maternity and paternity are outlined below.

1. **Prenatal leave and subsidy:** Granted to female employees 6 weeks prior to estimated delivery; duration: 42 days.
2. **Postnatal leave and subsidy:** Granted to female employees for 84 days following delivery to facilitate the recuperation of the employee and protect the health of the newborn. If the mother dies in childbirth or during the subsequent leave, this subsidy or the remainder thereof is paid to the person caring for the child, usually the working father. Female employees caring for a child under 6 months and who have initiated adoption proceedings are also eligible.
3. **Leave and subsidy due to the serious illness of a child under 1:** Every working woman is entitled to this benefit when her child under 1 requires home care due to a serious illness, a circumstance that must be accredited by medical certification. If both parents are working, either of them (according to the mother's decision) can receive this leave and subsidy. Workers who have a minor under their care for whom they have been granted court-appointed tutelage or guardianship as a protective measure are also entitled to this benefit.
4. **Postnatal parental leave and subsidy:** Authorization for the working mother to take time off from work to breastfeed and care for her child immediately following postnatal leave. This benefit can be used full-time or part-time, for 12 weeks in the case of the former, and 18 weeks in the latter. After the 7th week of leave, the mother

¹ Information about this program can be found in:

National Health Fund (FONASA) Website: www.fonasa.cl

Directorate of Labor Website: <http://www.dt.gob.cl/portal/1626/w3-channel.html>

Department of Social Security. (2011). *Documento de trabajo N° 1. Evolución de los Subsidios Maternales 2000 a 2010*. Available at: <http://www.suseso.cl/607/w3-article-18533.html>

Department of Social Security. (2015). *Documento de trabajo N° 4. Subsidio por Permiso Postnatal Parental 2011-2014*. Available at: http://www.suseso.gob.cl/607/articles-18537_archivo_01.pdf

may transfer part of the remaining leave to the father. However, leave continues to be full-time or part-time according to the mother's original decision. The daily value of the subsidy for postnatal parental leave is the same as that received by the mother during postnatal leave but is reduced by half if she chooses to return to work part-time. When the father makes use of postnatal parental leave, the subsidy is calculated based on his salary corresponding to the period used to calculate the mother's pre- or postnatal subsidy.

The above mentioned subsidies are equivalent to the salary of the female employee, specifically:

- Employees receive an amount equivalent to their net average monthly salary accrued in the 3 calendar months prior to the month in which medical leave begins.
- Employees in the public sector are entitled to continue receiving their salary but not a subsidy.
- In the case of independent workers, the calculation is based on the average of the net monthly income for which they contributed during the 6 calendar months prior to the month in which medical leave was initiated.

The subsidies and their respective values corresponding to prenatal leave, postnatal leave, postnatal parental leave, and leave due to the serious illness of a child under 1 are financed exclusively from fiscal resources.

5. **Maternal protection:** This consists of legal protection granted to women and aiming to safeguard their jobs in order to ensure that they have a source of income and can therefore feed and care for their child. It is directed at all female employees (who depend on an employer) enrolled in the retirement system. In the case of the death of the mother, it is extended to fathers and, in some cases, adoptive fathers or mothers. This protection prohibits an employer from terminating an employment contract without previous authorization from a judge with appropriate jurisdiction. In other words, only a court ruling can authorize the dismissal of an employee with maternal protection. Maternal protection extends from the initial pregnancy to 1 year after the conclusion of postnatal leave (excluding postnatal parental leave), or when the child is 1 year and 84 days old.
6. **Paternity leave for birth:** This consists of paid 5-day leave for the birth of a child, which may be used as desired from the moment of delivery, either continuously (excluding regular holidays) or distributed throughout the first month after birth. This leave is also granted to fathers undergoing the adoption process and available as of the time of notification of the resolution granting care or accepting the adoption of the minor in accordance with the Adoption Law.

Implementing agency or direct service providers: The Department of Social Security is responsible for the financial administration, formulation, budget execution, training, and supervision of the Unified Fund for Family Benefits and Unemployment Subsidy. The entities paying the subsidies are:

- Department of Public Health, which pays the subsidies granted to those enrolled in the public healthcare insurance system (FONASA) who are not enrolled in a Family Allowance Compensation Fund.
- Family Allowance Compensation Funds (CCAF), which pay the subsidies to their affiliates who are not enrolled in the Association of Private Health Insurers (ISAPRES).
- Association of Private Health Insurers (ISAPRES), which pays the subsidy to its affiliates.

Annual budget and funding source: USD 731.5 million (executed in 2017). The Unified Fund for Family Benefits and Unemployment Subsidy, from which the subsidies are paid, is financed exclusively from tax contributions set out in the Public Sector Budget Law.

Evaluation studies

Department of Social Security. (2015). *Subsidio por permiso postnatal parental 2011–2014*. Available at: http://www.suseso.gob.cl/607/articles-18537_archivo_01.pdf

5.2 Chile Grows With You (Chile Crece Contigo) Programs

5.2.1 Educational Program

Target: All children and their families.

Objective(s): Creating an environment and social context that encourages early childhood development (ECD) through educational interventions, awareness, promotion, and information aimed at the country's entire population. This program also seeks to inform, educate, and raise awareness about child care, respectful parenting, and early stimulation, encouraging the development of positive family and community environments that contribute to extending children's potential to the maximum in early childhood.

Main Characteristics: This is a program with universal coverage initiated by the Chile Grows with You (ChCC) initiative in 2007. It is based on a set of interactive communication and information platforms designed to raise awareness of the developmental needs of young children and guide adults regarding issues related to early childhood care and stimulation.

Intervention Strategy: This program includes the following components:

Platforms for information and user interaction:

- www.crececontigo.cl: Designed and executed as an information tool, this platform provides a space for consultation and interaction between adult users (parents or caregivers) and specialists (network of ChCC professionals). Given increasing demand and the availability of new digital tools, this web portal has been redesigned twice (2009 and 2017). It currently consists of various sections directed at families and ChCC teams organized by ECD stage, providing information and recommendations as well as a wide variety of audiovisual materials. From the outset, it has dedicated a section to the provision of services, where users can contact the ChCC team, including specialists in breastfeeding, parenting, and child health.
- Child Helpline (*Fono Infancia*): A free, confidential, nationwide phone service staffed by a team of psychologists specializing in childhood and family issues. It operates Monday to Friday, 8:30 a.m. to 7:00 p.m. It was created in 2001 as an attempt to contribute to the well-being and comprehensive development of children through the strengthening of skills in the adults responsible for their care and protection, with a focus on respect, the promotion of children's rights, and teamwork. This service is delivered by the Integra Foundation and has formed part of ChCC since 2007.¹
- Mobile app: During 2017, a downloadable mobile application for phones and tablets was made available to the public with information on ChCC, parenting, and childcare.

¹ Information about this program can be found in Fono Infancia Website: www.fonoinfancia.cl

Social networks: Due to the broad availability of Internet access in the country along with the growing use of social networks, ChCC has been expanding its digital footprint in a variety of spaces through the creation and administration of official accounts. It now has a Facebook page (<https://www.facebook.com/chcrececontigo>), a Twitter account (@CreceContigo), Instagram ([chcrececontigo](https://www.instagram.com/chcrececontigo)), and a YouTube channel.

Growing Together radio program:² From the beginning, ChCC has hosted a live national radio program once a week on a commercial broadcaster with a wide audience. It combines segments of conversations with specialists addressing a variety of topics related to childhood development, miscellaneous segments, and the delivery of useful information. All programs are available for broadcasting on community radios and can also be found on the ChCC website.

Educational materials:³ As part of the universal actions aiming to promote the delivery of relevant information on child development, for the past several years, the Educational Program has produced printed materials on a variety of topics, which have been distributed as part of ChCC awareness activities. These materials are available to the public on the ChCC website, where they can be accessed and downloaded. Some of the education and awareness materials for 2018 are as follows:

² Access to all radio programs is available at: <http://www.crececontigo.gob.cl/material-de-apoyo/programas-de-radio>

³ Further information on ChCC educational materials is available at: http://www.crececontigo.gob.cl/wp-content/uploads/2017/10/Catalogo-de-Materiales-ChCC_2017-OK.pdf

Name	Target Audience	Description
Important aspects of newborn care	Mothers, fathers, and caregivers	An educational booklet containing tips for recognizing warning signs in newborns; guidance for breastfeeding, bonding and effective calming techniques; a description of the abilities of newborns; and recommendations for early stimulation, hygiene, and the use of accessories such as baby carriers.
Active fathering and co-parenting	Biological and adoptive fathers, stepfathers, or those who have taken on a fathering role	Educational materials in both guide and brochure format aiming to promote and support the participation of the father or significant father figure in the parenting and care of infants from pregnancy through the first years.
Respectful parenting	Mothers, fathers, and caregivers	Educational materials in the form of booklets with recommendations to encourage parenting that respects the psycho-emotional needs of children in early childhood. The booklets center on 16 topics: <ol style="list-style-type: none"> 1. Respectful parenting 2. Active paternity 3. Breastfeeding 4. Bonding 5. Effective techniques for soothing crying children 6. Breast milk extraction and storage 7. Baby carrier handling and use 8. Massage 9. Sleep 10. Supplementary feeding 11. Early childhood stimulation 12. Language development 13. Playing without judging! 14. Dealing with tantrums 15. Weaning respectfully 16. Toilet training
10 things your child needs	Mothers, fathers, and caregivers	Two-page educational pamphlet providing guidance on early childhood stimulation according to 10 essential needs and how to best respond to them.
Promotion of language and communication skills	Mothers, fathers, and caregivers	Educational booklet containing information on language development and practical recommendations to encourage early learning.
Children and on-screen time	Mothers, fathers, and caregivers	Two-page pamphlet with recommendations for a healthy use of communication devices, ages not

		recommended for screen-use, and guidelines regarding exposure to advertising.
Children and transportation safety	Mothers, fathers, and caregivers	Three-page pamphlet containing information on the correct use of car seats and recommendations for the safe movement of children as pedestrians, cyclists, and passengers.
Labor rights	Mothers and fathers	A three-page pamphlet with information on the labor rights of pregnant women, mothers, and fathers.
Rights of pregnant women and child migrants	Mothers and fathers	Materials designed to promote the rights of pregnant women and child immigrants with respect to healthcare, education, and social protection.

Quality Assurance Mechanisms: The educational materials and information are developed by specialists in child development and validated by technical teams from the Ministry of Health (MINSAL), the Ministry of Social Development (MDS), and the Ministry of Education (MINEDUC).

Implementing agency or direct service providers: Ministry of Social Development (MDS) and Integra Foundation.

Annual budget and funding source: USD 4 million (executed in 2017) from the Public Sector Budget Law, Ministry of Social Development⁴.

Evaluation studies

ICCOM. (2010). *Estudio de informe de satisfacción usuaria del Sistema Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Informe_Final_Seguimiento-casos-usuarias-CHCC_Corregido-Final.pdf

CADEM. (2015). *Servicio de análisis de usabilidad, pertinencia, y satisfacción de los materiales entregados por el Subsistema de Protección Integral a la Infancia Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2016/01/Informe_Final-materiales.pdf

⁴ Ministry of Finance, Budget Division (DIPRES).

5.2.2 Biopsychosocial Development Support Program (PADB)

Target: Pregnant women and children ages 0 to 4 who use the public healthcare system.

Objective(s): Strengthening and promoting comprehensive early childhood development (ECD) from the first pregnancy checkup to the entry of the child into the school system. This program consists of a series of interventions designed to complement existing prenatal care, birth care, child healthcare checkups, and hospital care for children, when needed. In operational terms, the program seeks to coordinate and monitor the development of young children to help them achieve their maximum development potential.

Main Characteristics: To effectively deliver services, since its inception, the Chile Grows with You (ChCC) initiative has been equipped with a support system that begins with pregnancy and concludes when the child enters the school system at the transitional level, or around 4 or 5. This long-term support, which extends throughout childhood, is delivered via the Biopsychosocial Development Support Program (PADB) implemented by the Ministry of Health through the public network of healthcare facilities. The PADB program is the gateway to ChCC, the central program used to coordinate access to a series of services providing children with personalized support throughout their development. These include access to universal health services, assessments and screening for warning signs of biopsychosocial vulnerabilities, and consequent access to a variety of specialized support services depending on each child's characteristics, family, and context.

The PADB program incorporates evidence-based psychosocial interventions with a strong emphasis on local management. It should be noted that all of the services offered through this program are complementary to prenatal care, birth care, child healthcare checkups, and hospital care for children. These health services have a history of high rates of coverage and standardization, especially with regards to the biomedical aspect, which has resulted in excellent maternal and child health indicators over the last several decades.¹ The program's main innovations are the creation of new interventions² designed to complement and strengthen existing ones as well as their structuring into a technical management tool known as the Catalog of Services. This programmatic catalog is defined year by year by the Ministry of Health and the Ministry of Social Development. It guarantees the mandatory nature of the interventions included as well as PADB financing.

¹ Government of Chile. (2011). *Cuatro años creciendo juntos. Memoria de la Instalación del Sistema de Protección Integral a la Infancia Chile Crece Contigo 2006-2010*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/10/ChCC_MEMORIA.pdf

² The majority of interventions created as part of the Biopsychosocial Development Support Program (PADB) were designed based on previous small-scale experiences or pilot programs.

Intervention Strategy: The PADB program is a universal program aimed at all children and their families using the public healthcare system. Services are grouped into 5 areas or components, which are designed to accompany child development. These include: i) strengthening prenatal development; ii) personalized care for the childbirth process; and iii) strengthening comprehensive child development, in addition to two components aimed at children in situations of vulnerability or risk: iv) care for the comprehensive development of hospitalized children; and v) care for children in at-risk situations. Each component has clearly defined subcomponents and activities outlined in the PADB Catalog of Services,³ which is updated and made available to ChCC professional teams each year.

The components, subcomponents, and main activities are as follows:

I. Strengthening prenatal care: This component delivered through primary healthcare facilities.

a. Strengthening prenatal care: During admission to prenatal care, actions are taken to establish a supportive relationship between the professional in charge of the care and the pregnant woman in addition to screening for psychosocial risk factors through the application of the standardized Abbreviated Psychosocial Evaluation (EPsA). During this visit, pregnant women are also given the pregnancy and childbirth guide⁴ and the pregnancy healthcare booklet. As a result, the duration of this initial visit has been extended to 40 minutes (from 20 minutes) in order to ensure that time is available for all of the activities outlined.

b. Care for families in at-risk situations: Based on the results of the EPsA and the interview with the healthcare professional during the first pregnancy checkup (as well as in subsequent ones), a determination is made as to whether the family presents an at-risk condition. If it does, the following actions are taken:

- Design of a **personalized health plan** for the pregnant woman and her family: This plan is designed by the primary care team, which meets and evaluates the situation of risk shown by the pregnant woman and her family and determines the most appropriate interventions and referrals according to the needs identified. The municipal ChCC network is crucial to the delivery of this personalized health plan.
- **Comprehensive home visits:** This is a strategy for the delivery of health services based on creating a relationship of support between the interdisciplinary health team and the pregnant woman to encourage better environmental and relational conditions for the comprehensive development of the child. It takes place as part of the personalized health plan and the type of risk identified, and must have specific objectives guiding subsequent actions, evaluated on an ongoing basis during the care process.

³ For more details or to download the Biopsychosocial Development Support Program's catalog of services, visit: <http://www.crececontigo.gob.cl/material-de-apoyo/material-para-equipos-chile-crece-contigo/orientaciones-y-notas-metodologicas/?filtroetapa=gestacion-y-nacimiento&filtrobeneficio>

⁴ For more details, see Program File: Gestation and Birth Guide: Beginning to Grow (Guía de la Gestación y el Nacimiento - Empezando a Crecer).

- **Activation of municipal ChCC network:** This action is aimed at strengthening effective ties between the pregnant woman and her family and relevant services in the community. To this end, it is essential that each municipality have an updated record or map of the entire range of offerings available to families in terms of social services, employment, education, recreation, sports, libraries, and internet access, among others.

c. Education for pregnant women and partners (or trusted support person) and information on the Newborn Support Program (PARN): This consists of group educational activities and prenatal workshops aiming to provide cognitive and emotional support during pregnancy and to increase self-care and emotional well-being in addition to strengthening the physical and emotional preparation for childbirth and puerperium. Some educational sessions are also reinforced through the presentation of elements and content from the PARN program.⁵

II. Personalized care for the childbirth process: This consists of component delivered through hospitals with maternity wards in the public healthcare network.

a. Personalized care for the childbirth process: This subcomponent is designed to provide comprehensive and personalized care to the pregnant woman and her partner or trusted support person at various points in the childbirth process: during antepartum, delivery, and immediate postpartum. At the same time, attention is paid to the woman's emotional and physical needs, including timely pain management and consideration of cultural appropriateness. Actions are mainly focused on ensuring that the same professional provides ongoing care throughout labor and delivery and on encouraging the pregnant woman to be accompanied by her partner or trusted support person. An effort is made to provide information about alternative pain management,⁶ generate spaces for privacy, safety, autonomy and support within the maternity ward, allow the woman to choose the position she prefers in childbirth, and facilitate skin-to-skin physical contact between mother, father, and child from birth and up to 60 minutes afterward.

b. Comprehensive care during the puerperal period: This subcomponent seeks to deliver quality care to the entire family – mother, father, and child – and incorporates elements of healthcare and the promotion of physical and mental health. It also includes actions aiming to ensure efficient counter-referrals for women and families in at-risk situations and to strengthen coordination at this level and in primary healthcare, which is where follow-up on the evolution of the mother and her newborn child will take place.

⁵ For more details, see Program File: Newborn Support Program (Programa de Apoyo al Recién Nacido - PARN).

⁶ Pain management during labor and delivery is expressly guaranteed. For more details, see Program File: General Regime Governing Explicit Health Guarantees (Régimen General de Garantías Explícitas en Salud - GES).

III. Care for the comprehensive development of hospitalized children: This component is delivered through hospitals in the public healthcare network providing neonatal⁷ or pediatric⁸ services.

a. Comprehensive healthcare for newborns admitted to neonatology: This subcomponent delivers actions aimed at conducting a comprehensive evaluation, with emphasis on the detection of psychosocial risk factors and the development of a care plan according to the needs of newborns and their families through education and effective referrals. It also seeks to facilitate day and night support for newborns during the hospitalization process through a policy that allows for family visits (at least 10 hours per day). One of the main goals of this intervention is to prevent deficits in neurodevelopment through the customization of the physical environment of the unit and care plans along with the promotion of breastfeeding. It also includes an evaluation of the mother, father, or primary caregiver by a psychologist or social worker aimed at delivering, when needed, psycho-emotional support through crisis intervention. Accompanying educational actions seek to provide information on how the hospital unit functions, the health condition and capacities of the newborn, and care and preparation for the return home.

b. Comprehensive healthcare for children hospitalized in pediatric units: This subcomponent consists of actions similar to those described in the comprehensive care of newborns admitted to neonatology but with a strong emphasis on the restructuring of physical spaces that facilitate acceptance of hospitalization. These include: harmoniously decorated rooms, attractive designs of hospital gowns, age-appropriate toys, bedding with children's designs, space for educational activities, bathrooms adapted to the size and abilities of children, and comfortable and welcoming spaces. It also encourages making spaces available designed to facilitate children's play.

IV. Strengthening comprehensive child development: This component is delivered through primary healthcare facilities.

a. Strengthening health checks for child development: This subcomponent is divided into specific activities conducted during the first mother-child checkup following admission to primary care (assessment of the mother-child dyad), the child's initial checkup, and subsequent checkups designed to evaluate and monitor the child's comprehensive development. With respect to the **assessment of the dyad**, these actions are aimed at evaluating the health of mother and child within the first 10 days of the newborn's life, ideally 48 to 72 hours after being released from the hospital. Mother and child are monitored for risk factors detected during pregnancy or puerperium. This includes evaluating the initial adjustment or pairing between newborn and mother both in terms of basic needs and

⁷ In Chile, neonatal hospitalization is available for newborns up to 28 days.

⁸ In Chile, pediatric hospital services attend to children from 29 days up to 5 years of age.

bonding as well as providing educational information on stimulation and breastfeeding, among other actions.

The child's initial health check is designed to evaluate the child's health, developmental milestones expected for the child's age, the family context for growth, and the quality of ties with the main caregiver. A doctor applies the neurosensory protocol for the first month of life and looks out for new risk factors (biological, environmental, family-related) in order to formulate an initial response and prepare a personalized health plan for the primary care team, which defines the number of checkups, group education sessions, and home visits. Educational support materials are also provided depending on the family's needs and the baby's age, including educational booklets and audiovisual materials on respectful parenting.⁹ Lastly, **comprehensive checkups designed to evaluate and monitor the child's development** refer to actions aiming to encourage parents to participate actively in their child's healthcare as well as differentiated actions depending on the child's age, including:

- Evaluation of the presence of symptoms of anxiety or depression in the mother 2 and 6 months after delivery in order to detect potential postpartum depression by applying the Edinburgh Postnatal Depression Scale.¹⁰
- Evaluation of the psychomotor development of 100% of all children attending the checkup, in accordance with the specifications laid out in the technical guidelines: Psychomotor Development Scale (EEDP) from age 0 to 2 at 8 months and 18 months, and the Psychomotor Development Test (TEPSI) from age 2 to 5 at 36 months.¹¹
- Delivery of materials for early childhood stimulation: Discovering Together I at the 4-month checkup, Discovering Together II at the 12-month checkup, and Discovering Together III at the 36-month checkup.¹²

b. Educational interventions in support of development and parenting: This subcomponent consists of group education sessions for all parents and caregivers of children aged 0 to 5. In particular, it refers to the workshop on the development of parenting skills entitled *Nobody's Perfect*,¹³ the educational workshop designed to promote early language acquisition, and the workshop designed to promote the development of early motor skills, the last two being aimed at parents and caregivers of children aged 0 to 12 months and offering both fixed and flexible structured content.

⁹ For more information, see Program File: Educational Program.

¹⁰ For more details, see Box 6: Principal Development Screening Tools and Risk Factors for Chile Grows with You Infant Development (found in the main document).

¹¹ Ibid.

¹² For more details, see Program File: Informative and Educational Materials for Children - "Discovering Together" (Acompañándote a Descubrir).

¹³ For more details, see Program File: Nobody's Perfect Parenting Skills Workshop (Nadie es Perfecto).

V. Care for children in at-risk situations: This component is delivered through primary care facilities.

a. Strengthening of interventions for children in at-risk situations or with developmental lags or deficits: This subcomponent is focused on comprehensive and systemic healthcare with a biopsychosocial approach for children and families in at-risk situations¹⁴ or who reveal a lag¹⁵ or deficit in their physical, emotional, or cognitive development. It consists of actions designed for both children with developmental lags or deficits and those in at-risk situations. These include the creation of a personalized intervention plan based on the risk factors identified, referrals to ChCC child development support services and early childhood stimulation in healthcare centers,¹⁶ and preferential referral to the parenting workshop Nobody's Perfect. In the case of children with developmental deficits, the above-mentioned actions are accompanied by referrals to specialists in treating children with special needs, muscle tone, coordination or movement disorders, or congenital anomalies. These children are also encouraged to attend an early education program. Comprehensive home visits form part of this subcomponent and are aimed at families with psychosocial risk factors, giving priority to children in situations of suspected abuse or neglect, children with mothers or caregivers with intellectual disabilities or severe mental disorders, and children at risk of or showing psychometric developmental lags.

¹⁴ At-risk situations are those outlined in the Registration, Referral, and Monitoring System (SRDM) and consist of:

- Unrelated caregiver or non-legal guardian
- Mother with incomplete schooling
- Mother under age 17 and 11 months and in education
- Mother of child with permanent disability
- Child with high level of biomedical risk
- Child with abnormal or highly abnormal score on neurodevelopment evaluation
- Child with abnormal score on biopsychosocial risk guidelines for entry into the Child Development Support Program (MADI)
- Child with abnormal score on the attachment scale
- Child with score indicating a potential lag or risk on the Psychomotor Development Evaluation Scale (EEDP) or Psychomotor Development Test (TEPSI)
- Child whose mother shows an abnormal profile on the Edinburgh Postnatal Depression Scale
- Mother or legal guardian who is studying, working, or seeking employment and who belongs to the most vulnerable 60% of families
- Child housed in precarious living conditions
- Child with a permanent disability

¹⁵ Lags are detected using psychomotor development measurements. A lag is understood as a condition in which the child does not present all of the developmental skills or milestones expected for the child's current or previous age range, even though the overall score of the evaluation is within the normal range. If not treated, a lag can lead to a developmental deficit and is therefore a risk factor. It is crucial that efforts be made to respond to the situation, conduct an assessment, and provide the child with early and preventive care.

¹⁶ For more details, see Program File: Child Development Support Initiatives (Modalidades de Apoyo al Desarrollo Infantil - MADI).

Quality Assurance Mechanisms: The catalog of PADB services provides a guide to the delivery of activities and sets goals and standards for quality care. Additionally, there are two annual evaluations of key indicators in both primary and hospital care. ChCC healthcare managers in all 29 health services also create work plans for the strategic areas of management and implementation. Lastly, production indicators are set each year for primary healthcare facilities to measure those services defined as alerts, with a budgetary impact for municipalities since government funding falls if they do not meet the defined goals.

Implementing agency or direct service providers: Ministry of Health, through primary and secondary care centers and hospitals with maternity, neonatology, and pediatric services. Institutions forming part of intersectoral networks at the regional level also deliver actions, identified on the map of opportunities for each municipal ChCC network.

Annual budget and funding source: USD 28.3 million (executed in 2017) from the Public Sector Budget Law, Ministry of Social Development¹⁷.

Evaluation studies

Gesta Foundation and the Moviliza Corporation. (2009). *Análisis cualitativo del Programa de Apoyo al Desarrollo Biopsicosocial (PADB)*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/1-Informe-ejecutivo-Analisis-cualitativo-programa-de-apoyo-al-desarrollo-biopsicosocial.pdf>

Ministry of Health and Ministry of Planning. (2010). *Encuesta nacional de implementación Programa de Apoyo al Desarrollo Biopsicosocial (PADB)*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/2-Informe-final-Encuesta-nacional-de-implementacion-programa-de-apoyo-al-desarrollo-biopsicosocial-2008-2009.pdf>

Ministry of Health and Ministry of Planning. (2010). *Segunda encuesta nacional de implementación Programa de Apoyo al Desarrollo Biopsicosocial (PADB)*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/3-Informe-final-Encuesta-nacional-implementacion-programa-de-apoyo-al-desarrollo-biopsicosocial-2010.pdf>

Ministry of Health and Ministry of Social Development. (2011). *Tercera encuesta nacional de implementación Programa de Apoyo al Desarrollo Biopsicosocial (PADB)*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/3-Informe-final-Encuesta-nacional-implementacion-programa-de-apoyo-al-desarrollo-biopsicosocial-2010.pdf>

¹⁷ Ministry of Finance, Budget Division (DIPRES).

Pontifical Catholic University of Chile. (2010). *Levantamiento y análisis de información sobre desarrollo infantil y sus principales determinantes sociales y económicas en el contexto del Sistema Chile Crece Contigo*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/8-Informe-final-Levantamiento-y-analisis-de-informacion-desarrollo-infantil-y-sus-determinantes-en-contexto-ChCC.pdf>

Pontifical Catholic University of Chile. (2011). *Levantamiento y análisis de información sobre desarrollo infantil y sus principales determinantes sociales y económicas, para niños/as que se atienden en la red privada de salud*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/9-Informe-final-Levantamiento-y-analisis-de-informacion-desarrollo-infantil-y-sus-determinantes-en-red-privada.pdf>

Pontifical Catholic University of Chile. (2013). *Levantamiento y análisis de información sobre desarrollo infantil y sus principales determinantes sociales y económicas del grupo de niños pertenecientes al PADB, en el contexto del Sistema Chile Crece Contigo (grupo tratamiento)*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/13-INFORME-FINAL_Evaluacion-PADB.pdf

ICCOM. (2013). *Análisis de la implementación y funcionamiento de las Visitas Domiciliarias Integrales del Sistema Chile Crece Contigo*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/11-Informe-Final-VDI-ChCC.pdf>

5.2.3 Gestation and Birth Guide: Beginning to Grow (*Empezando a Crecer*)

Target population: Pregnant women entering prenatal care in the public health system.

Objective(s): To promote self-care by mothers and family preparation and involvement during pregnancy; to build confidence and provide the tools needed to enhance and promote the healthy development of the child once born by providing relevant and useful information to support the pregnancy, childbirth, and postnatal process. When required by the context, the initiative also seeks to foster intercultural dialogue between women belonging to an indigenous people and health teams throughout the pregnancy, childbirth, and postnatal process in order to ensure that indigenous children are born and develop in accordance with their people's own cultural practices.

Main features: Since the beginning of the Chile Grows with You (ChCC) initiative, it has been considered that the provision of information accompanied by quality, technically-validated content is key to raising awareness among the population about early childhood development (ECD), thus encouraging informed decision-making. This led to the development of the Gestation and Birth Guide, an educational tool with relevant, motivating, and useful information designed to support the pregnancy, childbirth, and postnatal process. The guide was developed with clear and simple information thanks to illustrations and supporting text designed to be shared among all family members, with content that is easy to read and integrate into routines and everyday life.

One prerequisite for creating the conditions for children and families to exercise their rights is recognizing, valuing, and respecting the identity and cultural wealth of those who belong to indigenous peoples. This intervention developed a strong intercultural focus by drafting different versions of the guide geared toward pregnant women and families that identify as indigenous people or as being part of a community with its own cultural ancestry. These versions represent each culture's worldview with respect to pregnancy and birth and are not confined to a mere translation of a standard version of the material.

Intervention strategy: One-on-one interventions consist in handing over the guide in a targeted and deliberate manner during the pregnant woman's first prenatal check-up. To this end, the health professional responsible for prenatal care takes the time to explain what the intervention is about and in particular to recommend reading its content gradually in keeping with the stages of the woman's pregnancy. The actions of the health professionals in relation to the dissemination and use of this educational material are guided by a methodological note on the Gestation and Birth Guide.¹ The note provides a description of the guide,

¹ The methodological note is available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2016/01/NM-GUIA-DE-LA-GESTACION.pdf>

recommendations regarding its dissemination, and various suggestions concerning using the information as support for the activities that take place in subsequent prenatal check-ups.

The guide's format lays out the pregnancy timeline for the reader in an intuitive manner, making it possible to quickly identify the relevant week of gestation, which encourages a gradual reading of the content and gives the reader a sense of being supported during pregnancy. The material contained in the guide is structured around information relating to fetal growth and development, physiological and anatomical changes in the woman, and caring for physical and emotional health, and more generally describes basic care during pregnancy. It also includes information on the activities and labor rights of pregnant women. In addition, the guide allows the mother and her family to record their own experience during the pregnancy so that it can be used as a reference for future pregnancies, whether hers or those of other personally significant women (sisters, daughters, relatives, or friends).

Following the training received by health professionals in their distribution, the versions adapted to the different cultures are distributed in the regions with the greatest concentrations of each indigenous peoples or human groups with specific cultural ancestry. The adaptations are as follows:

- Aymara: *Wawasana Thakipa*
- Mapuche: *Txur Txemuain, Creciendo juntos* ("Growing Together")
- Huilliche: *Treman Fach Foil Fuare, Creciendo con raíces fuertes* ("Growing with Strong Roots")
- Chilote: *Desembarcando en una Isla* ("Landing on an Island")
- Rapanui: *Pe nei te poreko hana o te na poki i Rapa nui*

Each version comes with its own methodological note designed for the health teams.²

Quality assurance mechanisms: The content of the Gestation and Birth Guide was developed, approved, and updated by specialists in the area. In addition, each version of the guide contains its own methodological guidelines designed for the teams responsible for its distribution. The intercultural versions were developed with the active participation of the communities for which they are intended, which also took part in training sessions with ChCC teams.

Implementing institution or direct service providers: Ministry of Health, through primary health centers.

Cost of the Gestation and Birth Guide and funding source: USD 1.70 for each guide distributed. Funding provided by the educational program budget.

² The methodological notes to the various versions of the Gestation and Birth Guide are available at: <http://www.crececontigo.gob.cl/material-de-apoyo/material-para-equipos-chile-crece-contigo/orientaciones-y-notas-metodologicas/2/?filtroetapa=gestacion-y-nacimiento>

Evaluation studies

ICCOM. (2010). *Estudio de satisfacción usuaria del Sistema Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Informe_Final_Seguimiento-casos-usuarias-CHCC_Corregido-Final.pdf

CADEM. (2015). *Servicio de análisis y usabilidad, pertinencia, y satisfacción de los materiales entregados por el Subsistema de Protección Integral a la Infancia Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2016/01/Informe_Final-materiales.pdf

5.2.4 Newborn Support Program (*Programa de Apoyo al Recién Nacido* — PARN)

Target population: Children born in maternity facilities under the public health system.

Objective(s): To support the development of children from birth by providing basic elements for their care, protection, and stimulation and to provide knowledge for mothers and fathers on stimulation, basic care, bonding, and early childhood development (ECD) following a responsible parenting approach.

Main features: In 2009, as part of the Chile Grows with You (ChCC) initiative, the Newborn Support Program (PARN) was launched to provide instrumental support for early physical care of the newborn, meet basic needs, and improve the satisfaction of psychological and emotional needs. Since its inception, the distribution of kits has been supplemented by educational sessions on how to use them and on various aspects of parenting. These educational sessions are organized by theme, duration, and the stage at which they are taught.

Intervention strategy: The Newborn Support Program is a one-on-one and group service conducted by professional midwives in all maternity facilities under the public health system. It contains three main components:

I. Education: Group educational sessions, where participants receive training on how to use the PARN objects and on early parenting with an approach that respects the newborn. This component is organized so that the educational sessions are held on two separate occasions:

a. Prenatal education on respectful parenting and on how to use PARN components.

This consists of one-on-one or group sessions as part of the third and fourth sessions of the prenatal workshops under the Biopsychosocial Development Support Program (PADB) in primary healthcare. The educational objectives focus on imparting information regarding how to use the content of the PARN kits as well as on early parenting, following a respectful approach to basic and early care such as: breastfeeding, physiological regulation of food and sleep, effective comforting, and early stimulation, among others.

b. Postnatal education on respectful parenting and on how to use PARN components.

An educational session is held after the child is born but before the mother leaves the public maternity facility (postnatal care) to provide an overview of the kit and to demonstrate in person how its components are used. In addition, content is offered on mother self-care during the postnatal period and on newborn parenting. These actions supplement the distribution of the printed educational materials.

II. Distribution and registration of the kit of basic components for the newborn: This component comprises distribution of the PARN kit of basic components. In 2018, it consists of:

a. Sound Sleep package: Flatpack crib with mattress, blanket, sheets, bedspread, and stimulation mobile.

b. Well-being, Bonding, and Stimulation package: Dual-purpose rack, backpack, baby sling, breastfeeding cushion, bath towel with hood, cotton diapers, clothes, plastic changing mat, massage oil, healing cream, liquid soap, early stimulation mat, two books (short stories and “My First Book”), stimulation mobile, educational DVD, and learning notebook.

III. Comprehensive postnatal and newborn care by strengthening the maternity and neonatal facilities of hospitals under the public health system. This component was integrated in 2017 and aims to:

a. Present projects designed to modify and kit out physical facilities to favor comprehensive childbirth care, prenatal and childbirth support, skin-to-skin contact between mother and newborn, rooming-in and breastfeeding, and reducing environmental stressors for newborns.

b. Present projects designed to enhance and kit out physical facilities together with the corresponding equipment in order to carry out audio or metabolic diagnostic screening studies.

Quality assurance mechanisms: The first mechanism for controlling the quality of the tools is random quality control, which is performed by the Supply Office for the National Health Services System (CENABAST). It receives consignments of products from suppliers together with the quality certificates requested from them as part of the bidding process. In addition, satisfaction surveys have been commissioned, resulting in modifications to the technical specifications of some products and the withdrawal of some and the addition of others as well as adjustments to the graphics and to the ergonomic design of the packages. In the event of dissatisfaction with the products, each establishment makes a formal complaint to CENABAST, which the logistics operator also accesses in order to respond to the claim.

Implementing institution or direct service providers: Ministry of Health, through the maternity facilities of hospitals under the public health system and primary health centers.

Annual budget and funding source: USD 22.1 million (executed in 2017), Public Finance Act, Ministry of Social Development.

Evaluation studies

Data Voz. (2014). *Satisfacción Usuaría del Programa de Apoyo al Recién Nacido*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/14Informe-Final-Satisfaccion-USUARIA-2014-Y-LINEA-BASE-sin-comentarios.pdf>

NOUS Consultores. (2013–2014). *Evaluación de condiciones priorizadas para el Programa de Apoyo al Recién Nacido (PARN)*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/10/Condiciones-priorizadas-PARN-MDS-2013.pdf>

ICCOM. (2011). *Informe de estudio de satisfacción usuaria del Programa de Apoyo al Recién Nacido*. http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Informe_Final_Seguimiento-casos-usuarias-CHCC_Corregido-Final.pdf

5.2.5 Informative and Educational Materials for Children – “Discovering Together” (*Acompañándote a Descubrir*)

Target population: Children aged under three served by the public health system.

Objective(s): To provide informative and educational material for the family with a view to promoting healthy child development, increasing the child's learning capacity, motivating the affective bond with surrounding persons, and providing concrete information about various aspects of child development.

Main features: Since the beginning of the Chile Grows with You (ChCC) initiative, the design and distribution of informative material to support families regarding child care and stimulation has been considered vital. The idea is to provide information, recommendations, and examples of activities conducive to healthy child development. The design of the educational material entitled “Discovering Together” was therefore organized around the different stages of development and aimed at all infants aged under 2 served by the public health system. This material has evolved over time to take into account various evaluation studies and the views of the technical teams and experts. In 2018, it comprises a series of informative and educational elements designed for children aged under 3.

Intervention strategy: This one-on-one intervention is designed to be part of child health monitoring activities. It takes place in primary health centers and is executed directly by a nurse, who distributes the kits (in keeping with the age of the child) in person, describes the material and its purpose, and provides guidance on its use.

For kit distribution, the health professionals and teams are guided by technical guidelines for this component, which describe the materials and their objectives and offer guidance on how to use them.¹

The following paragraphs describe the various materials and their distribution:

- Discovering Together I kit for children aged 4 to 12 months, comprising three finger puppets, a soft ball with sound, a set of stimulation cards, and a set of four colored cups. These toys are attractive and safe for babies to explore with their mouth, hands, and eyes. The puppets and animal cards also encourage a bonding game with the adult. Distribution takes place during the 4-month health check-up.
- Discovering Together II kit for infants aged 1 to 2 years, comprising a set of wooden blocks, a book with sounds, a set of stimulation cards, and an interactive picture book. Distribution takes place during the 12-month health check-up.

¹ This methodological note is available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/NM-Acompañandote-a-descubrir.pdf>

- Discovering Together III kit for children aged two to three years, comprising a coloring book, a CD of farm-themed music (*Juguemos en el Campo*), and a wooden jigsaw puzzle. Distribution takes place during the 24-month health check-up.

All “Discovering Together” objects are certified as non-toxic.

Quality assurance mechanisms: The materials selected and the distribution criteria were validated by a task force comprising experts from the Ministries of Health and Social Development. Non-toxic certification was listed as a prerequisite in the bidding documents for the materials. Methodological guidelines were also written for the teams responsible for distribution.

Implementing institution or direct service providers: Ministry of Health, through primary health centers.

Cost of the educational material and funding source: USD 8.10 for the three kits. Funding provided by the educational program budget.

Evaluation studies

ICCOM. (2010). *Estudio de satisfacción usuaria del Sistema Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/Informe_Final_Seguimiento-casos-usuarias-CHCC_Corregido-Final.pdf

CADEM. (2015). *Servicio de análisis y usabilidad, pertinencia y satisfacción de los materiales entregados por el Subsistema de Protección Integral a la Infancia Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2016/01/Informe_Final-materiales.pdf

5.2.6 Nobody's Perfect Parenting Skills Workshop (*Nadie es Perfecto*)

Target population: Mothers, fathers, and caregivers of children aged under 5 served by the public health system.

Objective(s): To promote the parenting skills of mothers, fathers, and caregivers of children aged under 5, addressing issues relating to child development.

Main features: Nobody's Perfect (NEP) is Chile's version of a parenting skills training program devised by the Public Health Agency of Canada, which began in the 1980s with the work of community nurses, who recorded the main concerns of parents of children aged under 6 and devised a teaching curriculum to cover all of these needs. The program has a strong psychosocial focus and aims to raise awareness and encourage prevention. In the context of the Chile Grows with You (ChCC) initiative and the National Health Strategy (2011–2020) and thanks to a cooperation agreement between the Chilean Ministry of Health and the Public Health Agency of Canada's Division of Childhood and Adolescence, in 2009, the Nobody's Perfect program was adapted to the Chilean cultural context.

Intervention strategy: Nobody's Perfect is a collective social service offered in primary health centers. It offers 6 to 8 two-hour sessions per week to groups of 8 to 14 individuals, comprising mother, fathers, or caregivers of children aged under 5. The sessions are conducted by primary health professionals trained as Nobody's Perfect facilitators by an official certified trainer who, in turn, has received direct training from a master trainer from Canada's Nobody's Perfect Parenting Program.

The groups are formed on the basis of similarities between the participating families, excluding people with a high degree of vulnerability, for whom one-on-one sessions have been designed. During the sessions, participants are given support with a view to having them devise positive child parenting strategies as a group. The program is based on a model of adult learning focused on participants and the family's strengths and involves talking about personal experiences, prior knowledge, and the participants' individual skills with a view to discussing and carrying out practical activities that show problem-solving strategies that can be positive for the child and the family. The program is based on the premise that since no one is born knowing how to be a mother or a father, everyone therefore needs information and support, as well as on the idea that group participation can help individuals identify their own strengths and needs. Respect is promoted for the cultural backgrounds and life experiences of all participants, and all are encouraged to express and vote on what they want and need to learn. The facilitator's role is to remain neutral and help the group find common ground, where the beliefs and values of all participants are respected.

Workshop participants can choose specific topics to be addressed during the sessions from a menu of options divided into five areas:

1. Physical development: Issues related to growth, health, illness, and nutrition; identification and early responses to common childhood illnesses.
2. Mental development: Aspects of cognitive and emotional development, the importance of play, and stimulation of children of different ages.
3. Behavior: Designed to guide the management and resolution of common behavioral problems by children's age bracket.
4. Safety and prevention: Identification, prevention, and management of the main risks of accidents to which children are exposed.
5. Self-care for mothers, fathers, and caregivers: Focusing on self-help among adults, the prevention of violence in the home, and strategies for adults to stay healthy.

Each of the topics comes with supporting material for the participants, organized into five books, with clear and straightforward text accompanied by color drawings and underlined key messages. The books for parents used in Canada were adapted to the language, culture, and physical appearance of the Chilean population, and its design was intended to make the text attractive and non-threatening for people with low levels of educational attainment. The program's adaptation also included the development of extra materials such as stickers with emergency phone numbers, posters promoting the program, and a DVD containing 30 animated clips on the topics covered in the books.

Quality assurance mechanisms: The workshops are organized and standardized thanks to a program designed to train Nobody's Perfect facilitators, which, in turn, is run by a certified facilitator trainer. There is also a Nobody's Perfect group facilitator manual.

Implementing institution or direct service providers: Ministry of Health, through primary health centers.

Funding source: Budget of the Biopsychosocial Development Support Program (PADB).

Evaluation studies

World Bank. (2017). *Evaluación de impacto del programa Nadie es Perfecto: Resultados post tratamiento*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2018/04/Finalreport_NEP_June24-Ok.pdf

Psychosocial Development Research Center (CEDP). (2013). *Estudio cualitativo sobre la implementación del taller grupal de competencias parentales Nadie es Perfecto*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/7-Informe-final-Estudio-cualitativo-implementacion-Nadie-es-perfecto.pdf>

5.2.7 Workshops on the Early Promotion of Motor and Language Development in the First Year of Life

Target population: Children aged under 12 months served by the public health system.

Objective(s): To improve psychomotor development by promoting freedom and autonomy in exploration among children under 1 year of age and promote language development, learning, and quality interaction and communication in children.

Main features: The tradition of educational workshops conducted in primary healthcare, reinforced by years of experience in the implementation of the Chile Grows with You (ChCC) initiative has encouraged well-being and improvement in the quality of life among the population and proved to contribute to adequate child development. In a complementary manner, the skills training strategy for sensory room professionals under ChCC has standardized and homogenized methods and built up experience in planning and running workshops to promote the development of children under 1 year of age. In addition to nationwide evidence, which reveals that a high percentage of children show changes in their psychomotor development and in the area of language, all of this information formed the foundation for the design and implementation of the educational interventions.

Intervention strategy: The workshops for early promotion of motor and language development consist of group sessions conducted in primary health centers by health professionals working with child development support initiatives).¹ They are targeted at children aged under 12 months, along with their mothers, fathers, or caregivers. They are open to all children who attend primary healthcare, regardless of whether they present known risk factors.

The workshops consist of 90-minute sessions, one hour of which is dedicated to execution with the participants, the other 30 minutes being geared toward the preparation of the physical space, closure, and evaluation, which is then recorded in each child's clinical file. The workshops combine fixed content consisting of theoretical or belief- or myth-based aspects addressed in all sessions combined with flexible content that can vary depending on the interests of the participants.

The empirical and scientific evidence and the nationwide relevance underpinning these workshops as well as the theory, structure, practical examples of activities and aspects related to the organization, implementation, and evaluation of the workshops to promote language

¹ For more details, see Program File: Child Development Support Initiatives (Modalidades de Apoyo al Desarrollo Infantil - MADI).

and motor development in the first year of life are explained at length in a manual dedicated to these workshops and produced for ChCC teams.²

Quality assurance mechanisms: To promote proper implementation of these workshops, supporting materials have been developed for the health professionals responsible for running them in order to standardize their content and methodology, with guidelines on child development support initiatives produced for local teams and a manual on workshops for early promotion of motor and language development in the first year of life. A 20-hour e-learning course has also been developed on workshops for early promotion of motor and language development in the first year of life.

Implementing institution or direct service providers: Ministry of Health, through primary health centers.

Funding source: Budget for the Biopsychosocial Development Support Program (PADB).

² The manual can be downloaded at: <http://www.crececontigo.gob.cl/wp-content/uploads/2016/04/Manual-Taller-promocion-desarrollo-lenguaje-y-motor.pdf>

5.2.8 Child Development Support Initiatives (Modalidades de Apoyo al Desarrollo Infantil - MADI)

Target population: Children aged under 4 served by the public health system, presenting delays, risk, or biopsychosocial risk in their development, determined via the application of biopsychosocial risk detection guidelines or a development test.

Objective(s): To fulfil the development potential of children presenting developmental delays, risk, or biopsychosocial risk while facilitating the coordination of specific support mechanisms for these children and their families in order to provide suitable care and stimulation for their children.

Main features: Since its inception, the Chile Grows with You (ChCC) initiative has been backed by management support mechanisms. Among these, the Child Development Intervention Support (FIADI) has the objective of financing child development support initiatives at the local level as a way of contributing to the supply of services in support of ECD. However, prior to the implementation of ChCC, there were already over 100 sensory rooms in health centers operating under different names (development and learning rooms in health centers, sensory rooms or nurseries in doctors' offices), illustrating the level of interest that child stimulation in healthcare contexts had aroused for decades.

Municipal networks under ChCC submit requests to FIADI for funding to set up and operate one or several support initiatives, and the Ministry of Social Development working via its regional ministerial secretariats finances and oversees the projects submitted annually. Care initiatives financed are: mobile stimulation services, sensory rooms, home care stimulation services, and improvement or extension of existing initiatives. The various initiatives are either one-on-one or group services geared toward children and their families, especially the mother, father, or caregiver.

Intervention strategy: Children are admitted to the various services offered by the child development support initiatives during health check-ups, where the full trajectory of child development is examined. In the event of the check-up detecting a developmental delay¹ or risk (via a development test), or biopsychosocial risk (via the application of risk detection guidelines),² the professional performing the health check-up must refer the child and his or

¹ Delays are detected via measurements of psychomotor development. A delay is defined as a state in which the child does not present all the skills or milestones expected for his or her current age bracket or for the previous bracket, even though the child total assessment score is within the normal range. Developmental delays are a risk factor that, if left untreated, can lead to a developmental deficit. It is therefore vital that an alert be raised before the delay sets in, an assessment carried out, and early and preventive care provided.

² The biopsychosocial risk detection guidelines for referral to a child development support initiative check for the following:

- Child with multiple visits to emergency services, health centers, or hospital.
- Child previously hospitalized for medium- or long-term stay.

her family to the sensory room or other form of support in a timely manner. In cases of children presenting a lag or risk in a development test or a biopsychosocial risk to development associated with an underlying medical condition, the child must be referred to a specialist as well as to a sensory room or other form of support.

Children can also be admitted to these initiatives on referral from other ChCC institutions (early education or community services) or by spontaneous request. However, admission must always be validated technically by referring the child to a health check-up in parallel with the beginning of care. This is so that the relevant background is factored into the child's intervention plan and in order to increase coordination. Once admitted to a development support initiative, an intervention plan is drawn up with the family and the child according to the affected areas of development. One-on-one and group sessions are provided in which the child is observed directly and daily activities are modeled with the family to promote the child's recovery in the areas of language and socio-emotional and motor development. The intensity and frequency of intervention will depend on the child's state of development and age.

The child development support initiatives consist in services with given specifications and methodologies:

- Mobile stimulation service: This initiative offers sensory experiences for children living in remote areas far from the urban center of their municipality.
- Sensory rooms in community centers or health centers: These sensory rooms are geared toward areas of high geographic dispersion that are difficult to access or those with a scarce or insufficient support for ECD. When there is demand not met by

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- Child with underlying medical condition (genetic syndromes, cerebral palsy, central-nervous-system pathology, among others).
 - Child with a teen mother or father.
 - Child whose mother has received less than eighth-grade schooling.
 - Child whose mother presents a disorder on the Edinburgh scale or if one or both primary caregivers present any mental health disorder (depression, substance use, personality disorders or mental disabilities, among others).
 - Child whose primary caregiver presents behavior suggestive of negligence in care or failure to meet the child's needs.
 - Child who lives in a single-parent household without family or social support network.
 - Child with a sibling with a history of child protection orders with change of caregiver, institutionalization, or adoption.
 - Child whose mother, father, or primary caregiver is incarcerated.
 - Child who is institutionalized in a nursing or preschool residence or in temporary care of a foster family.
 - Child growing up in an environment inconducive to care and development.
 - There is unemployment in the primary family environment.
 - Child whose home is in precarious conditions of habitability.
 - Child who lives in a family with significant social isolation or in an area of high geographical dispersion.
 - Psychological abuse.
 - Domestic violence or child witnessing violence.
 - Physical or sexual abuse.

another service and the municipality has a sufficient number of children in early childhood, creating a stable (not mobile) comprehensive stimulation service is appropriate and justifiable. Sensory rooms in health centers are designed to provide preventive and awareness-raising clinical and psycho-educational care in primary healthcare facilities. Care is provided in a temporarily or permanently dedicated room by health professionals trained in ECD.

- Home care: This consists in a series of stimulation visits to the home of the child presenting a delay or deficit carried out by technical or professional teams in order to provide a timely stimulation service in the home.

All child development support initiatives must be linked to the Biopsychosocial Development Support Program (PADB), regardless of whether or not they have been provided in a public health facility, with a clearly defined referral and counter-referral flow between the PADB and the corresponding initiative. Since their inception, the initiatives have been provided by instructors, who have faced an information-rich process of integration as education professionals in a team of health professionals. Teams have also included special educators, physiotherapists, speech therapists, and occupational therapists as well as psychologists and social workers with specific training in early childhood and social-emotional development, bonding, or other specializations. In summary, the ideal professionals for providing this care are found in the area of health and early education, with training in neurodevelopment, integrated child development, or early intervention, or are skilled at working with children and families.

Quality assurance mechanisms: The interventions carried out as part of the various initiatives are standardized, and the professionals who run these services have received training. In addition, technical guidelines are provided for running these child development support initiatives, and quality standards are applied annually by the Ministry of Health and the Ministry of Social Development.

Implementing institution or direct service providers: The program is coordinated by the Ministry of Social Development in conjunction with the Ministry of Health and is implemented by the municipalities (local government).

Annual budget and funding source: USD 4.1 million (executed in 2017), Public Finance Act, Ministry of Social Development. Funding for the sensory rooms in health centers is provided by the budget for the Biopsychosocial Development Support Program.

Evaluation Studies

Alberto Hurtado University. (2009). *Estudio ejecución y resultados de modalidades de intervención implementadas a través del Fondo de Intervenciones de Apoyo al Desarrollo Infantil*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/madis.pdf>

Catholic University of Chile. (2012). *Estudio para el mejoramiento continuo de las modalidades de apoyo financiadas por el fondo de intervenciones de apoyo al desarrollo infantil*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/2-Informe-final-Estudio-para-el-mejoramiento-continuo-de-la-calidad-de-las-modalidades-de-apoyo.pdf>

Medwave Estudios and CIGES (UFRO). (2013). *Estudio de costo-efectividad de las Modalidades de Apoyo al Desarrollo Infantil de Chile Crece Contigo*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/10-Informe-Final-CE-CHCC-12-2013-OK.pdf>

5.2.9 Child Mental Health Support Program (*Programa de Apoyo a la Salud Mental Infantil - PASMI*)

Target population: Children aged between 5 and 9 and their families from selected municipalities.

Objective(s): To deliver mental health care to children with mental problems or disorders and promote parenting skills, child development, and socio-emotional well-being among children aged 5 to 9.

Main features: Since 2016, the Chile Grows with You (ChCC) initiative has gradually expanded to the 5–9 age bracket with the main purpose of encouraging children to reach their full potential and promoting conditions for their development, well-being, and integrated learning in both family and school environments. In this context, the Child Mental Health Support Program (PASMI) has been gradually introduced with a view to narrowing the coverage gap in the care of mental health disorders.¹

Intervention strategy: The Child Mental Health Support Program consists of awareness-raising, prevention, and treatment interventions for mental health. It also works with programs implemented by the Ministries of Health and Education and the National Student Aid and Scholarships Board (JUNAEB). Its offering comprises two components, each with sub-components and specific activities:

I. Promotion of socio-emotional well-being: This component, which is offered universally, seeks to promote technical and relational aspects of promoting child development with a special focus on socio-emotional development, raising awareness about mental health disorders, and destigmatizing children with mental health problems or disorders. All of the above takes place through the multisectoral dissemination of educational content in various spaces (primary health centers, schools, and the community). Provision is undertaken by the Educational Program through its various platforms (website, social media, and radio program) and includes training for health teams and municipal networks. It also entails dissemination of communal recreation and hobbies offered to children aged 5 to 9, for which a periodically-updated local program diagnosis is vital.

II. Treatment: The package of care consists in a comprehensive diagnostic assessment carried out by at least two professionals (psychologist, doctor, social worker) and two medical consultations, all of which emphasize working with the family, and 9 additional mental health consultations with a psychologist.

¹ In 2016, gradual implementation of PASMI began in 17 municipalities. The program was continued in 2017, expanding to 23 municipalities.

III. Promotion of parenting skills: This specifically refers to a group workshop known as Nobody's Perfect,² which includes 4 sessions for mothers, fathers, and caregivers of children with behavioral problems (selective intervention). This is conducted in primary health centers by a professional trained in the Nobody's Perfect methodology.

IV. Social support in cases of psychosocial vulnerability: This is a personalized service for children who, in addition to being referred for assessment and treatment, present psychosocial risk factors such as socio-economic vulnerability, mother, father, or caregiver with mental health or cognitive problems, and school dropouts, among others. The actions included in this sub-component pertain to the activation of the municipal ChCC network, integrated home visits, and school visits. These actions are led from primary health centers by the health team in conjunction with the municipal network.

Quality assurance mechanisms: The program has technical guidelines designed to support team management and service implementation.

Implementing institution or direct service providers: Ministry of Health, through primary health centers.

Annual budget and funding source: USD 1.3 million (executed in 2017), from the Public Finance Act, Ministry of Social Development.

² For more details, see Program File: Nobody's Perfect Parenting Skills Workshop (Nadie es Perfecto).

5.2.10 Games Corner: Integrated Learning Support Program (*Rincón de Juegos - RINJU*)

Target population: All children entering Transition Level 1 (age 4–5) in public schools.

Objective(s): To improve conditions for exploration and play among children in Transitional Level 1 of elementary education, thus promoting their integrated development.

Main features: Since 2016, the Chile Grows with You (ChCC) initiative has gradually expanded to the 5-to-9 age bracket,¹ with the main purpose of encouraging children to reach their full potential and promoting conditions for their development, well-being, and integrated learning in both the family and the school environment. In this context, the Integrated Learning Support Program was included through the Games Corner initiative to provide instrumental support for increasing opportunities for free play among children aged 4–5.

Intervention strategy: The Integrated Learning Support Program comprises the universal provision of a Games Corner, which consists of a semi-rigid play tent that aims to foster play and exploration. It is given to all children when they enter the Transitional Level 1 of elementary education (pre-kindergarten).

In light of the scarcity of play areas for children and the fact that conditions at home often lack a suitable space, the Games Corner was designed as an object that can be assembled and disassembled with ease, making it usable for most homes regardless of size or characteristics. The fact that it forms its own room provides multiple options to foster exploration as it can be turned into whatever the child imagines, providing opportunities for numerous scenarios for free play or with guidance from mother, father, or caregiver.

The Games Corner comes in an easy-to-store box and consists of three main parts:

1. A reversible blackboard
2. A fabric tent
3. A hardboard structure

The kit is sent from the Ministry of Social Development in coordination with Ministry of Education to all public schools providing Transitional Level 1 elementary education. Once it arrives at the school, the social coordination team or whoever has been assigned the task by the school principal is responsible for delivery and registration.

¹ In Chile, children enter the formal school system aged between 4 and 5. This first level of education is called Pre-kindergarten or Transitional Level 1. Between 5 and 6, children move on to the next level, or Transitional Level 2, also called Kindergarten. Between 6 and 7, they begin elementary education, which comprises four school years or levels: Elementary 1 (6–7), Elementary 2 (7–8), Elementary 3 (8–9), and Elementary 4 (9–10).

The Games Corner includes the following support material for its delivery and subsequent use:

- Primer for educators: Material aimed at nursery teachers explaining the importance of play and how to promote it within families;
- Primers for families: Kit delivery includes two primers aimed at families. The first provides assembly instructions, while the second promotes its use and numerous possibilities.

Implementing institution or direct service providers: Ministry of Social Development (MDS) in conjunction with the Ministry of Education (MINEDUC).

Annual budget and funding source: USD 2.4 million (executed 2017), from the Public Finance Act, Ministry of Social Development.

5.2.11 Technical and Technological Assistance Financing Program for Inclusion (*Programa de Financiamiento de Ayudas Técnicas y Tecnológicas para la Inclusión*)

Target population: Children with a disability and belonging to households in the lower 60% of the national income distribution according to the Ministry of Social Development's socio-economic classification.

Objective(s): To promote the social inclusion of children with disabilities, leading to recovery and rehabilitation or preventing deterioration or change into another disability and to offset one or more functional, motor, sensory, or cognitive limitations in order to overcome barriers to communication and mobility with a view to full social inclusion.

Main features: Technical assistance for children with disabilities is understood as any external product consisting of devices, equipment, tools, or computer programs, manufactured specifically or widely available and whose main purpose is to maintain or improve people's independence or functioning and thereby promote their well-being. These products are also used to prevent functioning deficits and secondary illnesses.

The Technical and Technological Assistance Financing Program is part of the specialized services provided by Chile Grows with You (ChCC) and is implemented by the National Disability Service (SENADIS) and the Pedro Aguirre Cerda National Rehabilitation Institute (INRPAC).

Intervention strategy: Children presenting a disability are referred by ChCC teams (either health teams or municipal networks) for technical support in institutions with professional rehabilitation teams (regional hospitals or INRPAC). Drawing on their clinical and technical knowledge, these teams determine and prescribe the necessary technical assistance for each child and send the request to the relevant institutions.

Technical and technological assistive products are listed in a supply catalog and in an assistive product manual describing them and containing information on objectives, beneficiaries, safeguards, and other considerations regarding the products thus financed, which are classified as:

- Mobility aids: i) Products designed to help maintain body position (remaining seated or standing); ii) products designed to assist with movement, mobility, and transport; iii) wheelchairs; iv) assistive products for getting about the community; and v) products designed to carry, move, or use objects (upper and lower limb orthoses);
- Products for self-care, daily life, and accessibility;
- Assistive products for respiratory therapy;
- Assistive products for the care of body structures;
- Hearing and speech devices;

- Prosthetic devices;
- Visual aid devices;
- Products designed to facilitate the habilitation or rehabilitation process;
- Positioning and transfer devices;
- Assistive products for communication.

Quality assurance mechanisms: Catalog containing technical specifications and standards for assistive products.

Implementing institution or direct service providers: National Disability Service (SENADIS) and INRPAC.

Annual budget and funding source: USD 1.3 million (executed in 2017), from the Public Finance Act, Ministry of Social Development, with other funding sources from the Ministry of Health for assistive technologies.

Assessment studies

Dirección de Presupuestos (DIPRES) del Ministerio de Hacienda (2008). *Evaluación del Programa de Ayudas Técnicas del Fondo Nacional para la Discapacidad*. Available at: http://www.dipres.gob.cl/597/articles-141119_informe_final.pdf

Catholic University of Chile. (2013). *Levantamiento y análisis de información sobre ayudas técnicas para niños y niñas del Subsistema Chile Crece Contigo*. Available at: http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/13-INFORME-FINAL_Evaluacion-PADB.pdf

5.3 Chile Grows With You (Chile Crece Contigo) Tools

5.3.1 Information Management Tool: ChCC Registration, Referral, and Monitoring System (SRDM)

Users: Municipal managers, professionals from municipal networks (sectoral budget officers), and teams from regional ministerial secretariats.

Objective(s): To gather information on the users of Chile Grows with You (ChCC) that will make it possible to monitor the path followed by all children and their family.

Features and operation: In operational terms, monitoring child development means that the programs that are part of ChCC must constantly and continuously be identifying protective and risk factors for integrated child development with the purpose of alerting and referring children in a timely manner to more appropriate services and thus mitigate or eliminate those factors. This takes place through a series of contacts with ChCC users (children and their families), mainly in the context of health visits under the Biopsychosocial Development Support Program (PADB),¹ where the potential presence of these factors is examined either in an interview or using standardized tools. This process involves ongoing collection, storage, and use of information with a view to provide timely and relevant services promoting integrated child development. This ongoing information processing requires support if it is to facilitate the entry and retrieval of data when necessary and facilitate communication when one or more actors are involved in the coordination process.

Methodologies outlined in manuals, whether on paper or as spreadsheets, gave rise to a series of problems affecting the efficiency and effectiveness of the processes of data entry, retrieval, and use. This led to the creation of the Information Registration, Referral, and Monitoring System (SRDM), which was specifically designed to support the process of information exchange and accompany the developmental path of children and their families. It comprises four main features:

- All information entered is linked to the unique national identification numbers (RUN) of the child and caregiver.² This makes it possible to follow each child's path and not merely that of groups or institutional entities. Accordingly, individual information can be drawn upon to manage cases or improve services;
- It enables inter-operation with other government data repositories or databases, thus making it possible to retrieve data from other sources based on the user's RUN;

¹ For more details, see Program File: Biopsychosocial Development Support Program (Programa de Apoyo al Desarrollo Biopsicosocial - PADB).

² For more details, see Program File: Legal registration of a birth and allocation of a Unique National Identification Number (Rol Único Nacional – RUN)

- Since it is internet-based, there is no need to install software, requiring only an internet connection and a browser to use it. This makes the system user-friendly and easy to access;
- It is designed to be used by all sectors involved in the service supply chain (education, health, social services, among others), thus promoting system integration and traceability of services and of those who use them.

The system comprises three major modules, submodules, and sections, as shown below:

MODULES	SUBMODULES	SECTIONS
Data entry	Pregnant women	<ul style="list-style-type: none"> - Initial check-up - Contacts - Educational workshop - Home visit - Process end
	Children	<ul style="list-style-type: none"> - Initial check-up - Contacts - Group workshop - Home visit - Nobody's Perfect workshop - Child Development Support Initiatives - Process end

The data entry module is where data associated with each family covered by the public health system is entered. On the basis of this information, alerts can be triggered to activate the services and support required by families who present a risk to the integrated development of their children. This module is divided into two sub-modules: Pregnant women, and Children, which in turn are divided into their contact points with Chile Grows with You (ChCC), such as prenatal check-ups, home visits, group workshops, and results from the risk factor assessment tools.

Management	Actions	<ul style="list-style-type: none"> - Pregnant women - Children
	Reports	<ul style="list-style-type: none"> - Pregnant women indicators analysis (statistical information and case list) - Pregnant women list (full case history) - Children indicators analysis (statistical information and case list) - Children list (full case history)
	Processes	<ul style="list-style-type: none"> - Update information on pregnant women - Update information on children

The management module allows for the information entered in the data entry module to be used. It is divided into the following three sub-modules:

- **Actions:** Sub-module from which cases are managed, enabling each sector to record actions and the state of referrals or alerts produced in the data entry module;
- **Reports:** Three types of existing information are accessed through this sub-module: a) full case history, through which the service use history of the child and caregivers can be accessed and the identified risk factors consulted; b) tables containing lists of children or pregnant women presenting a condition, showing basic information such as name, RUN, and address, among others; and c)

aggregate information or statistical data, providing information on the number of children or pregnant women according to one or more characteristics;

- Statistics: Sub-module from which aggregate information can be viewed according to one or more attributes or characteristics and containing preset reports.

Statistics	SQL³ query	- Create new query
		- Stored queries
	Database	- Synchronize databases

The statistical module makes it possible to conduct custom queries on the SRMD database using SQL.

The SRDM has roles and six profiles: (i) data entry clerk; ii) Nobody's Perfect facilitator; iii) sectoral budget officer; iii) municipal manager; iv) regional manager; v) national manager; and vi) PADB health manager. This permits customized access to the various modules, sub-modules, and sections, and therefore to the information itself.

Quality assurance mechanisms: The Civil Registry and Identification Service (SRCel) is asked to check the identify of users who are entered into the system, and data is validated and audited internally.

Governance or institutional arrangements: The Ministry of Social Development (MDS) is responsible for the design, administration, maintenance, and updating of the SDRM. Data entry and bulk upload are carried out by the municipalities and sectoral ministries (MINEDUC, MINSAL, etc.).

Funding source: Funding for maintaining the SRDM is included under the information technology expenditure of the Ministry of Social Development.

Assessment studies:

EKOS Consultores. (2013). *Evaluación del uso e identificación de nudos críticos y mejoras al Sistema de Registro, Derivación, y Monitoreo (SRDM) de Chile Crece Contigo*. Available at: <http://www.crececontigo.gob.cl/wp-content/uploads/2015/11/8-Informe-Final-Evaluacion-del-uso-e-identificacion-de-nudos-criticos-y-mejoras-al-SDRM-1.pdf>

³ Structured Query Language.

5.3.2 Institutional Strengthening Tool: Municipal Strengthening Program (*Programa de Fortalecimiento Municipal - PFM*)

Target institutions: Municipalities implementing the Chile Grows with You (ChCC) initiative.

Objective(s): To support the management of municipal ChCC networks coordinated by the municipalities and enable participating institutions to make available to children and their families their entire range of services in a timely and appropriate manner.

To enable all institutions participating in the municipal ChCC network to provide information on other network participants and users and to make available to them the range of services for timely and appropriate care of the needs of all children and their family.

Main features and intervention strategy: To implement the ChCC initiative, each participating municipality creates a local network consisting of representatives from the municipality's social services, the health sector, and early education centers. Its objective is to coordinate oversight of the developmental path of children at the local level, monitor the various services, and issue the referrals and arrangements required to address situations that could affect the normal development of children. In this context, the Municipal Strengthening Program provides financial and technical support to the communal networks to help them meet the following specific objectives:

- Define care and referral mechanisms that allow the communal network to coordinate the services offered by Chile Grows with You in a timely manner;
- Implement training programs for early childhood teams related to early child development and stimulation;
- Populate and use the SRDM as a case referral tool, with the emphasis on determining actions to reduce vulnerability.

To allocate Municipal Strengthening Program (PFM) funds, the Ministry of Social Development (MDS) issues an annual call for proposals to all the country's municipalities connected online through an Agreement Management System (SIGEC). To take part, each municipal network drafts a proposal and a plan of action in a standard project format containing sections for its description, identification of managers, and descriptions of products, activities, means of verification, and lead times in accordance with each of the specific objectives mentioned above. The plan of action included in the project sorts the information and standardizes it for the various members of the network as the project must be built collectively and must comply with the agreements and actions that will be implemented by the municipal network during the PFM's implementation.

The monetary resources provided by the program are determined according to the characteristics of the child population of each municipality. Funds are transferred to the municipality through agreements, following a process by which the proposal has been reviewed, assessed, and approved by the Regional Ministerial Secretariat (SEREMI) for Social

Development. In operational terms, the funds provided by the program enable the municipal networks to:

1. Recruit staff to work directly on project implementation by performing the following tasks:
 - Annually update the local opportunities map, listing available services and initiatives designed to support child development in the municipality;
 - Annually update the local ChCC beneficiary guide;
 - Implement actions aiming to inform the community about ChCC and the range of services offered locally;
 - Draft reports on local ChCC activities.
 -
2. Provide training on child development topics for staff members from ChCC teams and the basic as well as wider municipal networks.
3. Recruit staff for administrative or managerial support to assist the population in the use of ChCC's Registration, Referral, and Monitoring System (SRDM) through data entry and continuous data monitoring.

Quality assurance mechanisms: The program has technical guidelines developed for municipal ChCC networks.

Governance or institutional arrangements: The Ministry of Social Development is the institution responsible for issuing the call for proposals, allocating funds, and through its regional ministerial secretariats, conducting technical and financial assessments of the proposals. The municipalities are responsible for coordinating project development with the participation of local representatives from the Ministries of Health and Education.

Annual budget and funding source: USD 4.1 million (executed in 2017), from the Public Finance Act, Ministry of Social Development.

5.3.3 Innovation Tool: Competitive Fund for Childhood Initiatives (*Fondo Concursable de Iniciativas para la Infancia*)

Targeted institutions: Municipalities and public or private institutions catering for children under 4.

Objective(s): To improve the public contexts and spaces in which children grow and develop.

Main features and intervention strategy: The Competitive Fund for Childhood Initiatives, which began in 2007, is a flexible fund that seeks to equip public spaces with a view to promoting and encouraging stimulation, play, and recreation among children from early childhood. To this end, it transfers funds to municipalities or hospitals and to nationwide initiatives such as story or music competitions.

Overall, the program funds the following types of projects:

- Equipping municipal public spaces for children;
- Equipping public spaces for child rearing;
- Music and story competitions for early childhood.

The Ministry of Social Development (MDS) through its regional ministerial secretariats (SEREMI) makes an annual month-long call for proposals inviting executing organizations to participate in the program by presenting a project in a standard format in one of the following categories:

1. Equipping public centers for children in municipal institutions and spaces, where municipalities are the direct executors;
2. Equipping childhood public spaces for child rearing, in partnership with the Directorate of Libraries, Archives, and Museums (DIBAM).¹ The municipalities are the executors.

The ChCC regional manager assesses the proposals according to a standard set of publicly available guidelines, in which the municipalities are ranked to determine the recipients of program funding. The entire process, including the application form and the technical and assessment guidelines, takes place via the online Agreement Management System (SIGEC).

A third category is aimed at the development of material for artistic stimulation and reader development in children from early childhood, which is implemented at the national level in partnership with the National Council for Culture and the Arts.² This competition is assessed

¹ The National Cultural Heritage Service, in accordance with Law No. 21.045 of 2017 creating the Ministry of Culture, Arts, and Heritage belongs to this ministry and is considered the legal successor of the Directorate of Libraries, Archives, and Museums (DIBAM).

² The Ministry of Culture, Arts, and Heritage brings together into a single entity the former Council of Culture and the Arts, DIBAM, and the Council of National Monuments.

by a panel of experts in music, children’s literature, and early child development. The artistic creations produced in the context of this competition are distributed among the various initiatives in order to equip public childhood spaces for child rearing and to the Child Development Support Initiatives (MADI) funded through the Child Development Intervention Support Fund (FIADI).³

Quality assurance mechanisms: Projects are monitored during their implementation (approximately 12 months).

Governance or institutional arrangements: The Ministry of Social Development (MDS) is responsible for issuing notice of the competition, allocating funds, and through its regional ministerial secretariats, conducting technical and financial assessments of the proposals. Calls for proposals, which are nationwide, are carried out in conjunction with the Ministry of Culture, Arts, and Heritage.

Annual budget and funding source: USD 0.7 million (executed in 2017), from the Public Finance Act, Ministry of Social Development.

³ For more details, see Program File: Child Development Support Initiatives (Modalidades de Apoyo al Desarrollo Infantil - MADI).

5.3.4 Budget Management Tool: Agreements for Fund Transfers to Institutions (*Convenios de Transferencias de Recursos a Instituciones*)

Targeted institutions: State institutions providing services to Chile Grows with You (ChCC), including municipalities.

Objective(s): To implement an intersectoral management model that provides oversight and control of allocated resources, linking budget allocations to systemic targets.

Main features and intervention strategy: The program of budget transfers between state institutions began to take shape more intensively in Chile in 2004, specifically for the *Chile Solidario* budget program.¹ In subsequent years, it was used systematically for intersectoral social programs and policies or where different state entities actively participate in funding, as is the case with ChCC. This budget management tool works as a conditional transfer, but between institutions that participate in a given intersectoral social policy or program. As the coordinating institution of the ChCC initiative, the Ministry of Social Development (MDS) signs funding transfer agreements with the Ministry of Health (MINSAL), the Ministry of Education (MINEDUC), municipalities, and other entities, in accordance with the following overarching rules:

- Transfer agreements are signed with: i) sectoral ministries; ii) public and private institutions supplying services and guarantees with prior approval from the General Comptroller of the Republic, where appropriate, providing the parties with legal and administrative validity; and iii) municipalities through regional units;
- Transfers are made based on requests recorded in the information system and in relation to available budget resources;
- A service level commitment is made, and the Ministry of Social Development (MDS) can set annual targets and standards;
- Payments are made according to a schedule of work based on specific results agreed to by the parties;
- Recipient institutions must account for their monthly spending and technical progress achieved within the framework of the agreement;
- In the event of failure to fulfil service commitments, the implementing entities must reimburse the funds.

The budget transfer mechanism is governed by a Fund Transfer Agreement signed between the coordinating institution and the institution receiving the funds. The agreement contains provisions regulating the following aspects:

- Alignment of the program run by the recipient institution with the overall objectives and results of the ChCC initiative;

¹ Renamed the Security and Opportunities Subsystem in 2012.

- Amount of funds to be transferred;
- Coverage of beneficiaries to benefit from the transferred funds;
- Phases or steps in which funds are transferred, i.e., disbursements to be made during the year and under what conditions;
- Reports the institution will be required to provide and minimum content of such reports;
- Penalties and reimbursements in the event of failure to meet the conditions specified in the agreement.
- Names and positions of technical managers in each of the institutions for the administration of the agreement;
- Conditions of SIGEC use.

Funds to be transferred to the institutions can come from various sources:

1. Regular budget resources, which must target the beneficiaries of the main program that transfers the funds (in this case, ChCC). These are not new budget resources but rather a reshuffling of existing funds;
2. Additional budget resources, or additional resources in a pre-existing program account. This source is used to combine resources so as to expand existing coverage or when changes are required to a specific program thus requiring more than the regular resources;
3. New budget resources, when a results-based program is created (in this case, for ChCC). This gives rise to a new budget program, and an institution is designated to receive and execute the funds.

Quality assurance mechanisms: Oversight and accountability is ensured through the Ministry of Social Development’s SIGEC agreement management system.

Governance or institutional arrangements: Ministry of Social Development

Total annual amount transferred through agreements: USD 68.3 million (executed in 2017), from the Public Finance Act, Ministry of Social Development.

