

Chile case study:

Building collective and institutional support for child wellbeing through Chile Crece Contigo

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1. Introduction

This case study is implemented within the project 'Fostering policy support for child and family wellbeing - Learning from international experience'. Using a thematic and analytic framework for the project that draws on Kingdon's multi-streams theory,² we are gathering and sharing evidence and learning on what has led to increased policy recognition of and policy change in family and child health and wellbeing (FCHW). In specific countries that have demonstrated policy recognition and change in FCHW post 2000, we are exploring within their context how different policy actors have come together to raise policy attention, develop policy options and promote their political adoption as processes for policy change, taking advantage of windows of opportunity for that change. The case studies were implemented with a local focal person with direct knowledge or experience of the policy process and include evidence from published and grey literature and interview of key informants involved in the policy processes.

This case study explores how Chile made a policy shift towards collective responsibility for child wellbeing through *Chile Crece Contigo* (ChCC), as a universal, integrated and comprehensive approach to family and child wellbeing.

Earlier policy ideas and movements were sustained and the universal health system defended during the 17 year dictatorship. This helped to take advantage of the window of opportunity that opened in 1989 at the end of the dictatorship, with the *Concertación* coalition bringing into government parties and people promoting more proactive, universal, rights-driven approaches.

In the late 1990s and 2000s, several social protection schemes were introduced to address poverty. ChCC went a step further towards a universal, rights-based and proactive investment to improve equality of opportunity across the life-course through early child development, drawing on growing evidence of the returns from such investment. It was given momentum by President Bachelet's election in 2005, reflecting her own experience and commitment. She set a political vision for it and brought technical, social and cross party actors into a Presidential Advisory Council to review evidence and make proposals that were widely owned and adopted after review by the executive.

Confidence in and support for the policy called for its rapid, effective implementation, including to advance its later enactment in law, in 2009. For this the near universal health system and existing services provided a means for ChCC to quickly reach communities with visible benefits. Services and municipalities were also supported by training, new resources for sectors and for co-ordination and active communication with all involved. Evidence is being used and communicated to demonstrate gain and support improved practice. With continuous change in socio-political conditions, actors and issues, it is recognised that ChCC needs to also keep showing its relevance.

2. The context

Chile is a high-income country in Latin America with 17.5 million inhabitants. It has 15 administrative regions and 346 municipalities, the majority of the population being urban (88%). It has high levels of adult literacy (96%). The country has had sustained economic growth over decades, but also a severe poverty gap and a Gini coefficient of 0.51 indicating high levels of income inequality (Frenz et al, 2017; Centre for Public Impact, 2016). The country is dispersed geographically, but well covered by internet and infrastructure. Seventeen years of dictatorship ended in 1989 with democratic presidential and congressional elections, with a Center-Left coalition, the *Concertación de Partidos por la Democracia*, winning power thereafter into the 2000s. Chile's political system is presidential, with a bicameral legislature (a Senate and Chamber of Deputies), regional executives and provincial governors.

The demographic transition is advanced, with 21% of the population 0-14 years and a population of over 60 years that is projected to reach 18% by 2020 (INE, 2014). It has also had a growing immigrant population, with this doubling between 2002 and 2014 to 2.3% of the total population (OECD, 2014). Average life expectancy at birth is 80.5 years. Poor health is associated with social determinants such as pollution, stress, social isolation and nutritional deficiencies (Ministerio de Salud, 2007). Chile's child and infant mortality and morbidity vary across regions, reflecting socio-economic disparities (Centre for Public Impact, 2016).

By 2000, demographic and epidemiological change, social inequality and poor user satisfaction were key challenges demanding reform (Barria, 2018). There was a long history of advocacy on social rights. In the 1920s workers organised around social demands for improved health care, and in the 1930s students on school meals and milk. Successive governments in the 1950s and 60s set public policies on social and children's rights, that have, together with Allende's 1970 [Programma de la Unidad Popular](#), remained in the minds of Chilean people.

During the 1990's, Chile's social policies in health, education and housing aimed to address universal access, to guarantee an adequate level of services and benefits for all, while specific programs targeted poor and disadvantaged groups to support uptake of services. Particular attention was given to children, youth, women, elderly people, people with disabilities and indigenous groups, and, more recently, immigrant populations (Frenz, 2007). A National Network of Health Services was created in 1952 to provide universal health coverage through a decentralized system of local public health services that was protected throughout the period of the dictatorship (MDS, 2017a). In 1970 in line with [Law 17.301](#), a National Commission of Nursery Schools was created to co-ordinate public and private early education and care (ECEC) services. Initially it focused on targeted assistance and, in the 1990s, on delivering quality ECEC. State ECEC services were complemented by non-profit entities, with training for ECEC by professional institutes and universities.

Despite these policy initiatives, social inequalities persisted in the coverage of these different services. After the end of the dictatorship and the holding of democratic elections in the 1990s, Chile began a process of strengthening social policies to not only react to negative outcomes, but to also address their causes, including in relation to the various deficits in living and working conditions experienced by many in the population (Vega, 2011). A range of social policy innovations were developed over the 1990s. While effectively implemented, they still covered only specific spheres or groups. They had weak cross linkages to build the synergies needed to effectively tackle complex social issues, including those affecting child wellbeing (Vega, 2011). This was a challenge Chile still needed to address as it advanced into the 2000s.



Source: [N Hamilton, 1987](#)

3. The policy change

El futuro de los niños es siempre hoy- Gabriela Mistral

This section describes the reforms in policy, law and institutional practice that were taken towards and in the adoption of Chile Crece Contigo. The next section describes how they came about.

Chile Crece Contigo (ChCC) emerged within a policy shift in the 2000s towards promoting social rights, including children's rights, together with the state's responsibility to progressively ensure these rights universally. *The most significant shift in the direction of social policies in Chile in the last 20 years... is the transition from a logic based on satisfying basic needs to one of guaranteed rights* (Hardy, 2011:159). Achieving this was recognized to call for approaches to address upstream determinants, including of child wellbeing (Vega, 2011; Barria, 2018).

In 2000-2002, the governing *Concertación* (the Coalition of Parties for Democracy), with Michelle Bachelet as health minister and Ricardo Lagos as President, took on this policy approach, including for child health, wellbeing and psychosocial development (De Buglio, 2014). The [AUGE](#) (Acceso Universal Garantías Explícitas), established by law in 2004 and initiated in 2005, set specific health service entitlements for all in the population as a universal guarantee.

Over the subsequent years a series of social protection programs were implemented that were aimed at social determinants. They built on Chile Barrio, launched in 1998 as a programme of intersectoral action on living conditions in precarious settlements; and included [Chile Solidario](#), launched in 2002 as a social protection system to promote social inclusion of families and people in extreme poverty and [Chile Emprende](#), launched in 2004, to improve income levels and employment conditions in an area-based approach. The Ministry of Planning and Cooperation (MIDEPLAN) played a role in the introduction of these programs, all aimed at different dimensions of poverty (Frenz, 2007).

While these social protection schemes remained targeted in their subsidies, the [Chile Crece Contigo](#) (Chile grows with you, ChCC) program deepened delivery on the political and policy intention to base the social protection system on rights and not only needs and to move from targeted to universal systems. In 2005, Michelle Bachelet published the 2006-2010 government programme, "Estoy contigo", in which the first years of life were identified as crucial in the development of the key skills and competencies that accompany people throughout their lives. The programme thus sought to support the stimulation and socialization that children receive at this stage and to address inequality in these opportunities for children (Bachelet, 2005).

In processes described further in the next sections, ChCC was launched in 2006 by President Bachelet in line with an electoral promise made to implement a child protection programme that would equalize development opportunities of children in the first four years of life and deliver a social welfare system that would accompany people throughout their lives.



Our goal is clear and simple: at the end of the first cycle of basic education, the various policies and programs contemplated in the child protection system must have erased the effect of socioeconomic origin on the abilities of children in Chile to learn and live together (translated from Bachelet 2005:15).

ChCC is thus a holistic approach to family and child wellbeing. It provides an integrated approach to early child development and support for parents and families in a manner that addresses the social inequalities that exist within Chilean society (Dighiero, 2015). It thus represents an important shift towards a comprehensive proactive, multi-sectoral approach to family and child wellbeing. It aimed to eliminate socioeconomic differences in achieving the maximum development potential of children across the social gradient (Vega, 2011). In doing this it took advantage of the foundation provided by primary care and community services in the nearly universal public sector health system.

The program begins with the mother's pregnancy and continues until children enter school at four years of age, extended in 2017 to nine years of age (Gobierno de Chile, 2009). In a way that is appropriate for each child, family, and community, it aims to give children the tools they need to cope with and face the specific risks of each stage of their growth to improve their life prospects.

Access to antenatal care serves as the entry point for mothers and children to join Chile Crece Contigo and to obtain from then on, as relevant to the life stage, school services, biopsychosocial, mental and oral health services for mothers and children, ECEC crèches and kindergarten places for children and the promotion of men's role in caring for children and co-responsibility. It provides access to benefits, child initiatives, a pack to support new parents; [various age specific tools for engaging with growing children](#) and interventions for healthy living.

On the understanding that early child development is only possible with a better quality of life, it involves services from different public institutions in health, education, and those dealing with children, youth, gender, labour and housing, together with social teams at local, municipal, provincial and regional levels (Dighiero, 2015; Barria, 2018). The support for children and their families aligns to their specific needs. It includes free nursery and pre-school access for vulnerable families; improved quality of prenatal care and childbirth; psychosocial and family support for children, especially for the first two years of life; health care access for all children from prenatal care until entry into schooling, with further support for children from low income or disadvantaged situations (Vega, 2011; Andrade et al., 2014).

New Parents Pack, ChCC



Source: [Chile Crece Contigo](#), 2019

Since 2007, the programme has been implemented in stages, co-ordinated by the Ministry of Social Development (MDS) and supported by technical instruments, tools, assistance and guidance (MDS, 2017). Municipalities are required to prepare a plan for their co-ordination role with the resource gaps they face and ChCC resources are disbursed to them to support capacities and co-ordination. ChCC personnel promote, supervise and certify facilities such as day care centers and nursery schools. Performance is monitored to show the changes achieved and to lever the support and supervision needed from the national level to achieve them. It is, however, also flexible, building on conditions, relations and capacities within municipalities (Frenz, 2007; Peralta, 2011).

The health sector played an important role in ChCC, not only as the entry point for families, but also as a strategic partner in policy formulation. The MIDEPLAN and MDS played a strategic role in facilitating collaboration across health, education and other sectors (Frenz, 2007).

As noted above, this made the near universality and equity of the health system an important 'backbone' for ChCC. The Ministry of Health developed *13 pasos hacia la Equidad* to improve equity in access to services and social determinants, while also investing in the competencies of parents and supporting home visits to support child health and development (Peralta, 2011; Barria, 2018).

The key reforms and some of the events leading to them are outlined in the timeline overleaf.

Timeline of the processes building to the establishment and implementation of Chile Crece Contigo

Year	Policy/ law/ program
1960s-1990s	10960s-70s: Family and child health and nutrition programs expanded nationally 1970: Law 17.301 passed creating the National Commission of Nursery Schools. 1989: Democratic elections brings in the Center-Left coalition, Concertación de Partidos por la Democracia; As Presidents 1990 P Alwyn, 1994 Eduardo Frei 1998: Chile Barrio (Chile Neighbourhood) introduced to contribute, through intersectoral action on living conditions to overcoming poverty in precarious settlements
2000	Election of Ricardo Lagos as President. Government work begins on the design of an initiative for action on the Rights of Children and the State's responsibility to ensure them as a universal principle.
2001	The Curricular Bases of Early Childhood Education and Care (ECEC) as a new national official curriculum approved by decree
2002	Chile Solidario (Chile solidarity) introduced as a progressive rights-based social protection system to promote social inclusion of families and people in extreme poverty
2004	Chile Emprende (Chile enterprise) introduced to improve income levels and employment conditions in an area-based approach. Legal establishment of the AUGE (Acceso Universal Garantías Explícitas - universal-access explicit-guarantees health plan) in Ley 19.966 with commencement in 2005
2005	Publication of "Estoy contigo" Government program 2006-2010 covering commitments to the stimulation and socialisation of all children in the first years of life. Ministry of Planning invited the Ministries of Health and Education to form working groups to review available benefits, identify innovative experiences and implement studies policy alternatives. Chile Solidario team at FOSIS and MIDEPLAN outline a proposal for an integrated social protection system for children 0 to 18 years of age
2006	President Michelle Bachelet elected and promises "to achieve a decent social welfare system that will accompany people throughout their cycle of life". A month after becoming President, a Presidential Decree is passed by M Bachelet establishing the Presidential Advisory Council for the Reform of Childhood Policies. Creation of the integrated and integral social protection system for early child development, Chile Crece Contigo, announced by the President.
2007	Chile Crece Contigo formally starts as an integral system of social protection for children 0 - 4 years old with an integrated system of benefits, interventions and social services to support the child and his/her family.
2008	Differentiated voucher scheme implemented for the most vulnerable children enrolled in primary education.
2009	Ley N° 20.379 <i>Crea el Sistema Intersectorial de Protección Social e institucionaliza el Subsistema de Protección Integral a la Infancia</i> , Chile Crece Contigo formally creates Chile Crece Contigo (ChCC) in law, General Law on Education (Law 20.379) passed defining the duty for universal ECEC and embedding the framework of ChCC in law. A Board set up to provide quality ECEC in the framework of ChCC through the creation, promotion, supervision and certification of day care centers and nursery schools managed directly or by third parties.
2010	Election of Sebastian Piñera as President.
2014	Election of Michelle Bachelet as President. ChCC extended to children up to 9 years of age and new momentum expanding ECEC to provide 45 000 new places for children between birth and 4 years of age.
2018	Election of Sebastian Piñera as President.

Sources: Bachelet 2005; 2006; Frenz, 2007; Vega, 2011; Peralta, 2011; Ministerio de Educación, 2018

The case study explores in the next section the actors, actions, processes and relationships that contributed to realizing these policy changes.

After a few early years of implementation of ChCC, in 2009, two important laws were passed. The first legislated the child protection system, including ChCC, [Ley N° 20.379 ,Crea el Sistema Intersectorial de Protección Social e institucionaliza el Subsistema de Protección Integral a la Infancia, Chile Crece Contigo](#). Complementing this a General Law on Education defined ECEC and set up a board to co-ordinate and oversee the provision of ECEC explicitly within the framework of ChCC, consolidating its institutional status (Peralta, 2011). Embedded within the universal approach were various targeted subsidies. A 2009 Supportive Chile Program gave 'preferred access' to vulnerable families to access the network of state services for early child development and family support, organized through the ChCC network in their area, while a differentiated voucher scheme in 2008 ensured enrolment of the most vulnerable children in primary education (Peralta, 2011).

As a further sign of the policy commitment to it, investment by the MDS in ChCC has grown from US\$2.7 billion in the 2007 initial installation phase to US\$8.1 billion in the 2008 expansion phase, followed by US\$27.6 billion in 2009 (Centre for Public Impact, 2016).

There is some evidence of the impact of these changes. Net attendance rates of 0-6 year old children in ECEC rose from 15.9% in 1990 to 37.4% in 2008 (Peralta, 2011). Between 2007 and 2014, nearly one million pregnant women enrolled in ChCC, with user satisfaction in the program at over 80% (Centre for Public Impact, 2016). Implementation of ChCC has improved coverage of crèches and kindergartens and of new places for children of mothers in the lowest income groups and working mothers, reaching the 2010 target of 60% coverage (Dighiero, 2015).

A later evaluation of the program in 2012-2016 found improvements in children's overall and emotional development and in their adaptive capacities (Barria, 2018). By 2017, the mothers' partner or family member was present at six in ten births. After specialist stimulation, 42% of children with developmental delay had caught up and the net rate of nursery school attendance had risen dramatically for children up to 4 year and to 90% amongst children aged 4-5 years (Bachelet, 2017; Ministerio de Educación, 2018).



Children in Santiago, Chile, Kirk, 2016

4. The story of the change

4.1 Raising demand for new approaches to family and child

This section explores the actors, processes and evidence that drew attention to and motivated the change in policy approach towards children's development reflected in ChCC.

Chile has had a history of autonomous community-led social mobilisation in some areas. Following the labour strikes and street demonstrations used by salaried workers to advance their issues, greater focus was given in the 1960's and 70's to strengthening the social organisation of peasants and more precarious urban workers. This open form of social organisation came to a halt in the 1973 - 1989 military dictatorship. Organisation was in secret to sustain ideas and many people went into exile. Some health professional associations were, however, able to defend the universal health system, using the scientific arguments. In the 1990s, a mass democratic movement was mobilised, new political entities formed and many exiles returned after end of the dictatorship. These movements focused on recovering democracy, on the transition from a military to a civilian state and on some key issues, including action on poverty. The window of opportunity of political change; the rapid socio-economic change in Chilean society and the raised expectations of social mobility led over time to the growth of a more informed citizenry, aware of rights and claiming entitlements, contributing to a socio-political debate that shifted away from viewing people as 'objects of need' to seeing them as citizens with rights (Hardy, 2011).

The growth of social expectation was added to by the fact that the targeted programs applied in the 1990s had made limited gains in reducing severe poverty. Poverty indicators measured by the 1998 and 2000 National Socioeconomic Characterization (CASEN) surveys showed that despite economic growth and a social expectation of wider improvement, beyond a reduction in absolute poverty there were no significant reductions in inequality and that regional differences persisted (Frenz, 2007). This brought the economic and social development model under question, triggering intense public, professional and political debate in the early 2000s on the problem of social inequality, its economic causes and on the inability of targeted social policies to address these concerns, as well as a demand for social rights (Vega, 2011). Various political actors, particularly those on the political left, demanded more decisive governmental action on social inequality and social development. Included amongst the ideas being raised domestically and by returning Chileans was that this called for investment in early child development. International evidence on the benefit of investment in the first three years of life had grown and it was argued that such investment could have a positive impact in closing social inequalities, especially in children.



Marches for social rights, Santiago, I Silva, 2013

When the *Concertación*, the Coalition of Parties for Democracy, an alliance of political parties that included parties and people raising these ideas, came into government in 2000 with Ricardo Lagos as President, it focused more on stabilization and a transition from military to civilian politics. It did respond to the demand for social rights, however, by advancing the AUGE, the guarantee of the health services that all in the population could expect, whatever their provider or area. Building on Chile Barrio the introduction of Chile Solidario in 2002 and Chile Emprende in 2004 reinforced the concept of state duties for state social protection in public dialogue.

It also showed that while still not universal, these broader, cross-sectoral and solidarity programmes made a difference. Evidence on the positive impact of Chile Solidario from the 2006 CASEN Survey indicated a fall in extreme poverty and a small change towards a more equitable income distribution. This showed the value of more comprehensive rights-based social protection approaches, while the Chile Solidario processes generated public learning that social entitlements could be viewed as rights (Frenz, 2007).

When Michelle Bachelet was elected as the first female president in 2005, the socio-political environment was thus more enabling for responding to social concerns, albeit still within the compromises of a cross party alliance in government. The attention of professional, institutional, social and state actors converged on aspirations for comprehensive universal approaches to address social wellbeing from childhood for all Chileans.

President Bachelet articulated this in her first address to Congress in 2006: *We intend to achieve a decent social welfare system that will accompany people throughout their cycle of life, protecting them in their first steps, ensuring them access to educational and work opportunities, covering them in case of illness or disability, and guaranteeing an adequate retirement. The construction of this system—with employment, educational, healthcare, housing and pension components—is a priority objective for my administration. This will be possible thanks to progress made in this country over the years.* (Bachelet 2006 in Vega, 2011:7)

In a process, described further later, President Bachelet set up a Presidential Advisory Council that involved a range of disciplines and took evidence from a wide range of technical, social, civil society and other sources. It engaged also at regional level and through a web platform to obtain social and institutional evidence and proposals on social priorities and approaches to address them. This pointed to deficiencies that stopped some in society from fully achieving opportunities that started from early childhood (Frenz, 2007). Early child development was thus a key focal area for this advisory group as the best means of achieving progress and social equity, with increased social investment in children seen as both a state duty and as an indispensable condition for more inclusive social and economic development.

The next subsections describe further how this political and technical support was organised and translated into concrete policies. Various forms of rights-based social activism have continued in Chile, albeit in a less concerted manner than in the earlier processes associated with the democratic transition. Social input has been organized in various mechanisms and forums (*dialogos*) to facilitate public input to services (Frenz, 2017). [Law 20.500](#) established social rights to public information and participatory public administration (Gobierno de Chile, 2012). However, these mechanisms are described as more information sharing and consultation-driven approaches than deliberative, empowering practices (Frenz, 2017). In health, with the acceptance of a right to a universal health system that was not reversed even during the dictatorship, the social mobilization has focused on areas such as the rights of patients. For example after journalist Ricarte Soto was diagnosed with cancer in 2010, in 2013, he catalysed a 'march for the sick' of about 5 000 people in different cities, to express popular discontent at the high cost of medicines and medical treatments (Alvarado, 2013). This led to a law, the 2015 *Ley Ricarte Soto* setting up a 'National High Cost Drug Fund'.

Social activism has occurred where systems are not seen to deliver on social rights. For example, education as a right has not yet been adopted in Chile. In 2006, hundreds of thousands of high school students, known as the *Penguins* because of their black and white school uniform, mobilised across the country to demand that education should be a right, not a privilege (Santibañez, 2018:1). In 2011 this student mobilization was repeated with a demand for free, public, quality education.

There has also been social organization on issues of gender and non-discrimination, with social debate organized by the National Institute for Youth, the National Corporation for the Development of Indian Peoples and the National Fund for the Disabled (Frenz, 2007). The women's movement has grown in strength and visibility in recent years, raising attention to gender rights. Hence, while the initiative for ChCC shifted after 2002 to political and technical processes, there are social movements and debates that may yet raise further issues on the policy agenda for child wellbeing.

4.2 Political leadership as a lever of policy change

The launch of ChCC by the political leadership in 2006 to some extent preceded rather than followed technical work on policy design and practice. This leadership support is thus discussed in this subsection while the next discusses how this was operationalized into the policy content of ChCC.

The introduction of Chile Barrio in 1998 under Eduardo Frei's presidency and Chile Solidario in 2002 and the AUGE and Chile Empeñe in 2004 under Ricardo Lagos' presidency reflected presidential and social priorities for poverty reduction (more so than reduction of inequality) and were overseen by the President's office. The Lagos government supported the escalation of social spending, including during adverse economic cycles. As noted earlier, while this reduced poverty, distributional inequalities remained virtually unchanged (Hardy, 2011).

While these changes reflected a shift away from targeted, needs-based welfare towards comprehensive, rights-based social protection, there continued to be a demand to deepen the universality of these approaches and to not only limit risks and but also to open opportunities across the life course (De Buglio, 2014). Various Presidential Commissions and 'dialogos' involving intellectual 'think tanks' such as [Fundacion Chile 21](#) debated and proposed approaches for how to do this, including in relation to pension reform, education reform, decent work and economic equity (Frenz, 2007).

In the early 2000s under President Lagos, the demand to ensure stability of the democratic transition and to move from military to civilian politics limited the extent to which a more radical policy agenda could be pursued. Even in 2005, the political compromise of a coalition government constrained the policy possibilities, given lack of consensus on some areas in the coalition and concerns at the resource implications of the proposals. Key sections of civil society that may have supported, such as the trade unions, had been weakened by economic and labour market changes and the media largely reflected major economic interests.

The introduction of ChCC was thus unusual for its universality and rights approach, and for the resources that were applied to it to support sectors and the cross-sectoral approach. It provided a political response to the social expectation that the resources generated from economic growth would be applied to improving social conditions and social equity. It reflected a perception of social protection as not being *emergency or transitory policies but as permanent policies, enshrining hard-won social rights* (Hardy, 2011:173). The focus on early child development came at a time when there was growing evidence that investment in children from the earliest years yielded a high return and was itself a contributor to future economic wellbeing. Studies such as that of James Heckman's, the Nobel prize winner for economics were reported to have pointed to the strategic value of investment in early childhood.

Nevertheless, the universal rights-based principles it was based on were not without political contestation. The political consensus on ChCC did not extend to the adoption of a concept of children having rights as individuals in their own right. In the second Bachelet government in 2014-2018, for example, a Bill tabled for the congress to put children's rights in law could not pass, with a lack of consensus across the parties; over resource implications; a perception of how the diversity of families would perceive the consequences of children having autonomous rights; and links made in the debates to issues such as abortion and gay marriage.

Hence, while ChCC as a proposal to invest in a comprehensive approach to early child development children's was less easy to contest, its political adoption was given strength by the personal political commitment of the President herself and her firm positioning of the improved opportunities for all children as a unifying objective of her government: *My goal, at the end of my Government, is have instituted a Protection System for Children destined to equate development opportunities for Chilean children in their first eight years of life, independently of their social status, gender, geographic origin, the structure of their home or any other potential factor for inequity* (Bachelet, 2006 in Frenz, 2007:45).

President Bachelet's own background as a mother during a time of new ideas and practice in socialist Chile in the 1970s and in exile, her orientation as a paediatric and public health specialist, her concern with social inequality as a member of the Socialist Party and her experience as a health minister with the health consequences of inequality may have contributed to her resolve to address inequality and to improve opportunities from the first years of life. Significantly, it has been a sustained priority throughout the two terms of her Presidency. *Early childhood is and will remain my first priority as President. And not in the words, but in the facts, like the ones we see here, and throughout Chile. Each new kindergarten, each new nursery that we inaugurate allows us to go a step further in the commitment we made with the country to build a fairer Chile, with less inequality and more opportunities for all* (M Bachelet at the inauguration of a kindergarten in Barria, 2018:33).

This political commitment to children resonated with and was perceived to provide a key means to achieving the wider political values she articulated for Chile: *This will be about consolidating a society that not only acknowledges freedoms, but also defends and promotes them. The State must not only outline rights; it must guarantee them to all its citizens. We intend to achieve a decent social welfare system that will accompany people throughout the life course, protecting them in their first steps, ensuring access to educational and work opportunities, coverage in case of illness or disability, and guaranteeing an adequate retirement* (Bachelet, 2006 in Frenz, 2007:4).

In October 2006, therefore, President Bachelet, announced the creation of ChCC as an integrated social protection system for early child development, to be implemented from 2007. The political intention was that it accompany children and their families from gestation until they entered the school system at age 4 years. It should provide universal access to benefits and services for all children to meet their emotional and physical needs and support their early childhood development.



President Bachelet celebrating the Day of the Chile, Chile Government, 2014

The next subsection describes the steps taken to turn this political commitment into institutional actions and to support its implementation. This process too was, however, not simply technical. It also depended on and widened political support. The program was, for example, conceived of as incremental in its progression, to take into account the realities and issues for the different sectors involved.

Making pregnancy the entry point for ChCC took advantage of the fact that Chile already had high coverage of the antenatal services in the public system, guaranteeing wide access and making it immediately visible to a significant majority of people. It was initiated first in half of the municipalities in the first year, choosing not only those with stronger maternal programs, but also those where there was interest to implement it and to learn from the experience, building a learning network of implementers (Ortiz, 2013; Bedregal et al, 2014). In the second year it was extended across the country, with formal agreements signed with all local governments on their role in the program and the support they would receive from national level.

Indeed, it took three years from its launch for a comprehensive legislative proposal to be tabled on ChCC. During this time the political support had to be maintained for the measures and legal amendments needed and for budgets needed to implement ChCC to be approved by the parliament (Dighiero, 2015).

Beyond the processes indicated above, the government set up participatory bodies, Presidential Advisory Committees, to foster political agreement between and support from the divergent political forces in the parliament, to facilitate the passing of ChCC in law (Hardy, 2011). As a sign of cross party political support, central government funded the program despite a cost of more than US\$10 billion for the first two years alone, while local government is also reported to have shown commitment by facilitating its rollout (Center for Public Impact, 2016).

When government changed in 2010, therefore, and a new political party took power, the political momentum weakened. It was a sign of the cross party support that had been built for ChCC and the positive view of the program by the range of professionals and institutions involved in its prior period of implementation that the Law 20.379 was still unanimously approved by the new government of President Piñera (Bedregal et al., 2014). The law set the objectives of the program to accompany, protect and fully support the development trajectory of all children; and to support their families through universal actions and services in a multidimensional approach; giving further support to vulnerable children and families.

It set out the political aim to providing *an integrated system of benefits, interventions and social services to support the child and his/her family ... to develop their maximum potential, in order to [create equality in] development opportunities* (Center for Public Impact, 2016:1). Having a legal framework was important to ensure the continuity of ChCC. It was significant, therefore, that the cross party and local support built for it meant that it was not reversed after the change of government, even if it received weaker levels of investment.

When the second Bachelet government was elected in 2014, it represented an opportunity to enhance the resource base for ChCC, to widen the program to include up to 9 year old children and to expand services and social protection programs.

This was done through tax reforms, but here too the changes introduced were reversed after elections in 2018 with the new Piniera government. While these political swings affected a number of policy proposals and may have affected the deepening of ChCC, they have not reversed it. The factors noted earlier, and its design, scale up and institutionalization, described in the next section, may have contributed to its continuity.

4.3 Framing the policy measures and supporting policy uptake

This subsection outlines how various actors and processes gave flesh to the political commitments to ChCC and supported policy uptake.

During the period of President Lagos, work began through the Chile Solidario team to design a comprehensive child protection system within Chile Solidario. While the learning and management teams and capacities that were built in Chile Barrio, Solidario and Emprende helped in framing the integrated approaches of ChCC, there was also a view that it needed to not only include strategies to *reduce* poverty, but also to *prevent* it (Frenz, 2007; Hardy, 2011).

In 2005 the Ministry of Planning invited the Ministries of Health and Education to form working groups to review available benefits, identify innovative experiences and commission studies to explore policy alternatives. This work in 2001-2006 helped to generate technical consensus, evidence and initial proposals for a rights based social protection system, termed *Red Protege*, which informed the principles for the design of ChCC (Hardy, 2011; Frenz, 2007). It envisaged a system that would protect people throughout their lives, combining monetary transfers with development initiatives to equalize opportunities (Hardy, 2011).

In 2006, President Bachelet President convened a new Presidential Advisory Council for the Reform of Childhood Policies, as committed to in her electoral platform. She tasked it with assessing the status of child protection and its shortcomings, to formulate and propose suitable policies and measures for a child-protection system that would give all children the same social opportunities (Dighiero, 2015). The Advisory Council had 14 members that were appointed to reflect a political balance and experience with childhood policies, such as H Molina, a health professional with international experience in PAHO on ECD.

The Presidential Advisory Council



Source: Courtesy of Helia Molina, Chile

Over the 6 months that it worked, the Council built broad social, stakeholder and technical consensus on proposals for the program. It assessed scientific literature, case studies and expert opinions from around the world. In line with the political intentions set by the President, the Council reviewed evidence of the impact of and returns from investments in early child development and the range of gains achieved.

Chilean economists such as Andres Velasco and Marta Harneker and institutions such as CEPAL provided evidence on the economic benefit of social investment. The Council convened and listened to diverse public and private organizations and groupings working on childhood issues. It held public hearings throughout the country that involved thousands of Chileans, while others submitted feedback online (Centre for Public Impact, 2016; Dighiero, 2015).

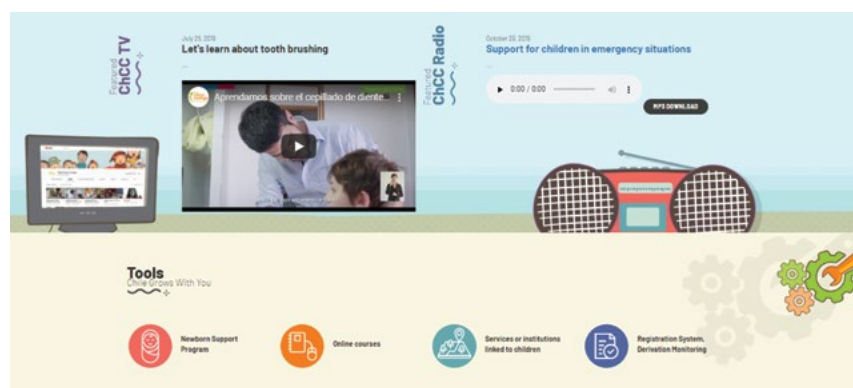
The Council's proposals were advisory and their review and policy adoption remained with government and Congress. After completing its work in June 2006, the conclusions of the Advisory Council were analyzed by a Social Ministries' Council. This body assessed the technical, financial and political viability of the Advisory Council's proposals, to propose the final strategic directions and implementation plans. It was chaired by the then Minister of Planning, involved ministers from labour, health, education, housing, gender and finance and was supported by a technical secretariat and technical committees consisting of legal and professional teams from the participating ministries (Dighiero, 2015).

The Ministries' Council took into account the possibilities for implementation given the organizational capacities, culture and resources available and the political framework and principles articulated by the President and used this to draft law and guidelines for implementing the reforms. For example while the advisory council proposed that the program cover children to 9 years of age, the Ministries' Council reduced this to a 4 year age limit for the first 5 years of implementation, to ensure adequate capacities and successful delivery (Comisión Infancia 2006).

Given the involvement of numerous sectors in ChCC, its co-ordination was placed in the Ministry of Social Development (MDS). At the same time the health sector, having the strongest service infrastructure and access to community level was identified as the entry point, through pregnant women attending antenatal care, making with links to other key sectors for the other services needed for child development. As a principle, the decision was made to use services that were already working, making changes and inputs as needed in these, such as in terms of capacities, materials or equipment. The main policy elements of ChCC thus built on a platform of existing services and added elements in stages as it developed. This enabled the program to draw evidence and learning from implementation, to inform and strengthen both the model and the processes for managing and implementing it and to point to new issues to address, such as mental health (Barria, 2018).

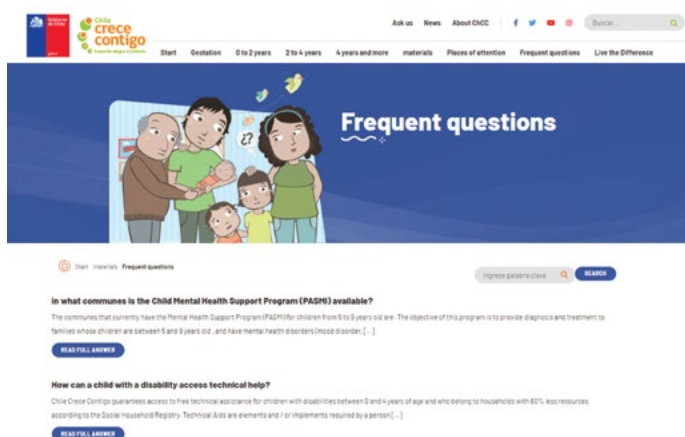
As noted earlier, its introduction in 2007 firstly in the 159 municipalities that were certified to have capacities for it on five criteria and that volunteered to accept it helped to demonstrate its feasibility and to build confidence at central level and in other municipalities. Several further features of both the design and implementation were important to enable the subsequent scale up to all municipalities in the country, implemented at a rapid pace to build visibility and legitimacy.

The first feature was the application of resources to support the program and its co-ordination. Budgets for the activities in ChCC were provided from the finance ministry to the sectors involved for the services they offered, especially to address gaps in their existing resources, boosting budgets, especially in health and education. The MDS received a new budget for co-ordination activities, as did the municipalities for their role in this and for the necessary competencies and materials needed to co-ordinate the program in their area. Each municipality set up a working group (Mesa) of the different sectors, to review the process and its implementation. Meetings were held in municipalities or groups of municipalities for local health practitioners, social workers, childcare providers and other key personnel to meet each other and learn about their roles during the roll-out. These implementer networks were supported by clear policy goals, national supervision and regional coordination. The transfer of resources and establishment of plans for ECD were seen to have been important motivators for the municipalities, but so too was their perception that the program would address concerns in their area, like poverty. Training programs were held to strengthen municipal capacities, drawing on local experience (Frenz, 2007; Centre for Public Impact, 2016). At the same time, the commitment varied across municipalities, depending in part on the political interest in children of the mayor of the municipality, the strength of the social team, the historical identification with Chile Solidario and the capacity of the health sector, given its role as an entry point.



Information resources on the ChCC website, online at <http://www.crececontigo.gob.cl/>

The second feature was the communication with the implementing teams and families. The implementation of ChCC implied a cultural change, in the attitudes of the teams attending to women and children and in the families themselves. It demanded communication from national to local levels and within each level. *This change will generate effectively a new discourse, a different approach that has to accompany this process of growth and development... to listen to the mother and hear her problems.* (Health official in Frenz, 2007:54). Some teams were resistant, in both the pre-schools and the health services. The training helped to reorient personnel. It was complemented by other processes, such as online platforms for information and training, volunteer physicians answering questions and motivating teams. The level of co-ordination across sectors depended on the issue. For example, the biopsychosocial issues required greater levels of co-ordination.



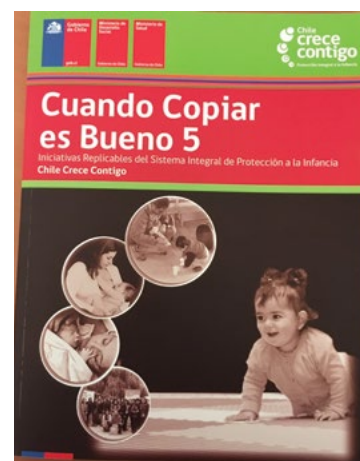
Support for parents at ChCC website, online at <http://www.crececontigo.gob.cl/>

The cultural changes also implied a new discourse for families and parents on children, on protecting their rights and ensuring their physical, mental and affective development. This not only affected mothers. It also affected the fathers and others in the community involved with development of children, as well as the different professionals in the team that supported families. Many workshops in a *Nadie es perfecto* (no-one is perfect) program were implemented to promote understanding of child development and the services offered. These processes continue up to today. Materials for families were also distributed as songs, story books and radio programs, and packs for new parents to support child care.

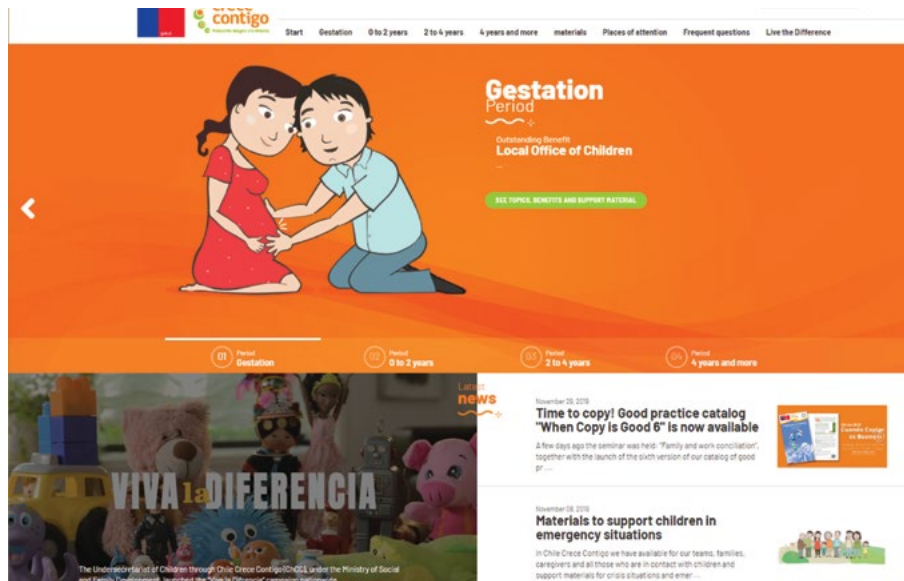
The *Programa de Apoyo al Recien Nacido (PARN)* provided a [pack of materials](#) to new parents to support their care of their new infants, including a baby carrier, a mattress and bedclothes for the baby, a breastfeeding cushion, baby clothes, a bath towel, a DVD with information, an educational booklet, illustrated stories, a stimulation mobile and other materials. This was greatly appreciated by families. Some areas had health promoters that helped with social understanding and uptake. These inputs and the experience of service personnel are reported to have led to a change in social attitudes to ECD. However, while there are general processes for social dialogue in municipalities (*diagnósticos participativos*), ChCC has no direct formal mechanisms for social representation in the inter-sectoral round tables used to discuss new challenges affecting children, such as migration and violence, or formal mechanisms for discussion with communities as a group their views on how to improve the functioning of the program.

As a third feature, the program involved active production, sharing and use of information and evidence. This took place at the level of services sharing information on individual cases. It was also stimulated by active support for learning from practice, including online, and by evaluation of the performance of the program. Evidence was key for those involved to review their work and to review the program as a whole. There is wide access to internet in the country and a software platform was designed in 2007 to enable workers in the different services to send alerts to other relevant services on individual cases referred and to get a response from them on the actions taken. It allowed all providers across the network to enter data about enrolled families and track their children’s progress, to monitor the delivery of benefits and the results of actions. It fed the information to higher levels to facilitate the monitoring of performance. Positive experiences and innovative practices have also been shared nationally, such as in the publication adjacent.

Supporting exchange of experience



Source: MSD Chile Crece Contigo



Information resources on the ChCC website, online at <http://www.crececontigo.gob.cl/>

The policy design for ChCC, while given clear direction by the political leadership within a clear philosophical framework, has thus blended evidence, expert opinion and input from wide public discussion in its development (Frenz, 2007). It has built learning and input to the design from implementation, integrating systems for implementers to review and exchange on the program to improve on its performance. The program has also invested in measures to build relations across the local actors and leaders and their networks, the teams of personnel from health, education and other sectors and others that bring it into the homes of families and children (Chile Crece Contigo (2010).

Evidence is seen to play an important role in both facilitating support from political and sectoral decision makers, and for informing the learning by implementers. In 2014 a [set of seven performance indicators](#) were developed. They address whether there is an active profile for each sector in the area and access to the registration, referral and monitoring system. They capture the level of family reporting to and use of the system (alert); the actions taken to resolve an alert (activity), the outcome and intermediate and final results.

Colour coding of performance indicators



Source: MSD Chile Crece Contigo

The indicators are gathered and reported locally and to national level, although the regions have no direct input to shaping or analyzing them. At national level they are analysed to assess the relative performance of communes and regions, using the colour coding shown adjacent, as well as to identify where improvements have occurred. This evidence is used in forums (jornadas) and monthly videoconferences nationally and with regions to discuss inequalities in performance, coverage and benefit and to identify the inputs needed to improve performance. Local level review takes place in some municipalities, where interdisciplinary primary care teams meet with the working groups (Mesas) on how to implement and improve the program (Frenz, 2007; Centre for Public Impact, 2016). There is, however, an identified need to strengthen this. Further, ten years on an external evaluation of ChCC is being implemented using a mix of methods, including a retrospective cohort, satisfaction studies and analysis of outcome data.

The feedback loop from policy implementation is thus being actively used to review and renew support for ChCC. It also raises new issues for policy dialogue and practice, such as the current dialogue between MDS and municipalities on making urban public spaces more child-friendly.

5. Summary of and learning on key drivers of the policy change

5.1 Summary of key drivers and processes fostering policy change

ChCC emerged within a policy shift in the 2000s towards promoting social and children's rights, including state responsibilities to progressively ensure these rights universally. With the health service as an entry point and starting with the mother's pregnancy, it continues until children enter school to nine years of age, with health, education, social protection, parental support and other sectoral interventions to give children the tools they need face the specific risks of each stage of their growth and to improve their life prospects.

Within Chilean society, a political platform of public policies on social rights set in the 1950s, including for children, remained in the social mind-set, despite subsequent decades of dictatorship, and health professional associations were able to defend the near universality of the health system. The limited gains in reducing poverty from the targeted approaches being applied for social protection, despite economic growth, generated social and professional debate and pressure for more effective policies to address social inequality.

The end of the dictatorship in the late 1990s opened a window of opportunity for these debates to have more formal policy impact, particularly with the inclusion in the Concertación, the Coalition of Parties for Democracy, of parties and people that had raised ideas for more proactive, universal, rights-driven approaches.

In the earlier stages of government in the late 1990s and 2000s, a focus on stabilization and a transition from military to civilian politics led to more cautious, but still significant shifts towards more comprehensive approaches, including through the AUGE health service guarantees and the income and employment subsidies in Chile Solidario and Chile Emprende. While still more reactive to poverty than proactive in improving opportunities across the lifecourse, they reinforced the concept of state duties for state social protection in public dialogue and showed evidence of gains from such approaches.

ChCC was a qualitative change from these prior policy initiatives in its universality and rights-based approach, positioning social protection not only as a reactive response to risk, but as a proactive investment in improving equality of opportunity across the life-course. Its focus on early child development came at a time of growing evidence of the returns from such investment.

The launch of ChCC by the political leadership in 2006 to some extent preceded rather than followed technical work on its policy design and practice. It was given political momentum by the election of Michelle Bachelet as president in 2005, albeit still within the compromises of a cross party alliance in government. Reflecting President Bachelet's experiences from socialist Chile through dictatorship as a mother, paediatrician, public health specialist and then in government as health minister, her resolve to address inequality and improve opportunities from the first years of life was a sustained priority throughout both terms of her Presidency.

President Bachelet initiated processes that built political cross party, technical cross-sectoral and social support for this political commitment in policy. She set up a Presidential Advisory Council that involved a range of disciplines and political parties that, over six months, took evidence from a wide range of technical, social, civil society, international and other sources. Their policy proposals were subject to further review and adjudication by a council of ministers before their adoption. This broad, transparent process strategically engaged diverse actors and also progressive domestic intellectuals, who could inform and support the political directions set.

The implementation of ChCC in its early years also played a role in the process of the policy change, not least given the several years before it was being enacted in law. It was implemented in stages, supported by formal agreements, technical tools and guidance. The public sector health system provided was an important 'backbone' for it to quickly reach communities, building on an important decision to use services that were already working and to draw learning and make relevant changes from implementation.

While the specific steps are described in the case study, several features of both the design and implementation helped to enable the rapid pace of national scale-up needed to build visibility and legitimacy during a single electoral period. The first was the application of resources to and co-ordination of the program, with increased budget allocations to the sectors involved and new resources for co-ordination and capacities for the municipalities. A second feature was the active communication between the centre and the implementing municipalities, sectoral teams and families, given the cultural change it implied for all. Thirdly, the program actively produced, shared and reviewed evidence from individual cases to collective performance indicators.

The cross-party and sector support and a growth in professional and public support for ChCC is evidenced the ten-fold increase in investment in it from US\$2.7 billion in 2007 to US\$27.6 billion in 2009/ It is also evident in the unanimous passing of Law 20.379 securing ChCC, despite electoral change and a more conservative government in 2010. A feedback loop and evidence from policy implementation is now being actively used to review and renew the program. It has generated and communicated evidence of the positive impact of the implementation of ChCC. A formal external evaluation currently being implemented will provide further evidence for policy dialogue.

Nevertheless, there continue to be challenges to sustaining or deepening the policy and program. There is still political contestation on the concept of children's rights and disruption of the political continuity needed to embed the policy principles of ChCC, given electoral swings and coalition governments.

The analysis of evidence and dialogue on learning from implementation still needs to be strengthened at local level, including to engage political and social support from the regions and municipalities and their constituencies. The social movements that initially supported ChCC have become weaker, while others, such as the women's movement, have grown. There is recognition that both politically and technically, ChCC needs to keep showing its relevance to new social conditions, influencers and issues.

5.2 Learning and insights on the facilitators of policy change

The summary describes the social, technical and political levers of the policy, legal and program change that led to ChCC in Chile and that have sustained a feedback loop to policy and social support from its implementation. The evidence and reflections from those involved in the policy changes in Chile suggest some further insights and learning from the experience.

In raising and keeping the issue on the policy and political agenda, look for a common ethical, political and technical framework and involve the people in the vision of the program and as owners of the policy. To do this it is necessary to focus on what is common and not what is different and to keep a close watch on people's views of and satisfaction with their experience of the delivery on the policy. (Studies in Chile indicated for example a 95% satisfaction rate with ChCC). Where relevant key informants noted using international agendas and policies to reinforce domestic proposals. At the same time situations are changing and people and policy actors draw information for new sources, including whatsapp groups and social media. It is important to listen to and engage with people in these new processes to avoid losing a connection with them and the way they perceive their priorities.

For the development and adoption of policy options, the decision to work with what exists and to build on it was an important one, as was the decision to start with pregnant women as the entry point for children. It built an upstream, life course approach that all understood and felt involved with.

Embedding the ChCC in and its synergies with the family health system enabled its rapid introduction and scale up, as did active communication with, orientation and capacity building of professionals. Many programs are delegated to health, however, and there is need to constantly strengthen other sectors and the links across programs and in the referral system to avoid silos. For example, SENAME, as a program for the most vulnerable children, such as abused, abandoned children and those in prison, runs parallel to ChCC, with its own co-ordination mechanism, despite the policy intention that ChCC deal with all children.

ChCC has had interest from and linked with experience other countries, such as in the [Colombia program](#) (Lopez, 2009) and [in the Uruguay Crece Contigo Institucional by MIDES Uruguay](#). A network of countries implementing or seeking to implement similar programs has now exchanged experience. In 2018, for example, a conference organised hosted by the MDS Chile included delegations from Palestine, Romania, Bulgaria, Nicaragua, Guatemala, Cote d'Ivoire, Burkina Faso and Niger in a discussion on policies and programs supporting child development.

However, policy doesn't end with its design. Feedback from implementation is critical for both improving and sustaining policies. Good information is key and cross sectoral work calls for an inter-operable computerized information system that not only reports from local to national levels, but also links local actors for review. While having a hierarchical society with respect for authority enabled a top-down introduction of ChCC, such strategies need to change with changing social conditions.

In building political and public support and sustaining policy implementation, political champions and signals from the highest levels played an important role, building the vision and motivation to achieve the goals, to position and sustain the policy in a competitive political environment. Central political support needs to be supported by political understanding at the regional and municipal level and by the technical support from key sectors, such as the finance ministry. The latter is particularly important as policy innovation needs resources! Hence while political levels can pass law as a key means for visibility and continuity, many other measures are important to build or reinforce political support, including performance evidence. This includes visible gains for beneficiaries to build public and electoral support - such as with the PARN materials for new parents - or the implementation of pilots or evaluations to show results and build experience and confidence.



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Endnotes

- 1 Acknowledgements for key informant input integrated into the text from Helia Molina, Univ. Santiago of Chile; Jeanet Leguas and Felipe Arriet, Ministry of Social and Family Development; Loreto Canales, ChCC Salud Pedro A. Cerda and Clarisa Hardy, Instituto Igualdad, Chile. All graphics under creative commons/open license or used with permission.
- 2 See Loewenson and Masotya (2018) for information on the conceptual and analytic framework used.