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Strengthening Early Childhood Development Policies

and Programs in Latin America and the Caribbean

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Strengthening Early Childhood Development

Policies and Programs in Latin America and the Caribbean*

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1. Introduction and Objectives

The objective of this Policy Note is to provide a tool for countries in the Latin America and the Caribbean region to take stock of Early Childhood Development programs and policies in their territory. By benchmarking against other programs and policies across the region, countries can identify options to strengthen Early Childhood Development.

In The Promise of Early Childhood Development for Latin America and the Caribbean, Vegas and Santibáñez (2010) put forth key building blocks for countries to achieve comprehensive ECD policies. These building blocks are based on the premise that all countries' share the goal of ensuring that children have adequate experiences during early childhood, which will enable them to reach their full potential during childhood, youth, and into adulthood. Vegas and Santibáñez (2010) also document the state of ECD indicators in the region, which show great disparities across countries and within countries.

Signed in February of 2010, the Partnership between The World Bank, ALAS Foundation, and Columbia University's Earth Institute intends to advance on previous efforts and develop a possible roadmap to achieve comprehensive coverage of quality ECD services for all children in Latin American and Caribbean countries. This roadmap recognizes that each country in the region is at different levels of development in terms not only of coverage of ECD services but, equally important, in the definition of its policy goals and vision for ensuring that all young children, from conception to age six, have access to comprehensive services to develop to their full potential.

In Latin America and the Caribbean, too few countries have made ECD a national priority. Access to ECD services varies widely by country, regions within countries, types of services, and the background of individual children and their families. In order to help countries interested in improving access, quality, and equity of ECD services, in the rest of this Policy Note, we:

1. **Define** Early Childhood Development and distinguish between ECD programs and ECD policies.
2. **Introduce** a typology of ECD programs and use it to categorize several interventions in Latin America and the Caribbean.
3. **Develop** a framework for classifying ECD policies at the national level, designed to help countries identify (i) their current level of development in this area, and (ii) some policy options to further develop ECD policies.
4. **Discuss** 3 case studies of countries in the region, Colombia, Panama, and Chile, to provide examples of how the frameworks can be utilized to identify policy options to strengthen national ECD policies and specific programs.

2. Defining Early Childhood Development, Programs and Policies

Throughout this Policy Note, we refer to Early Childhood Development as the period from when a child is conceived to six years of age (0-6). Experiences during the first six years of life affect the development of a child's brain and provide the foundation for all future learning, behavior, and health (Shonkoff and Phillips, eds. 2000). Recent work by Nobel Laureate James Heckman and his colleagues convincingly shows that factors operating during the early childhood years play an important role in the development of skills that determine outcomes later in life (Cunha and Heckman 2007; Heckman 2006; Cunha et al 2005; Carneiro and Heckman 2003). Research has also convincingly shown that early childhood interventions can act as an important policy lever to equalize opportunities for children and reduce the intergenerational grip of poverty and inequality (Heckman 2006).

Developing healthfully during the early years and acquiring adequate physical growth, as well as cognitive (such as language and mathematics skills) and non-cognitive skills (such as social, emotional skills and self-discipline) are important determinants of success in school, at work, and in life more generally. Importantly, a child's family environment is central to her development of skills and ability; hence, early interventions targeted to make up for some early family differences contribute to reducing early inequalities. Further, parental environments and family income available to children during early childhood are far more decisive in promoting human capital and school success than in the later years.

In sum, three types of outcomes in early childhood are critical for life outcomes. These include:

- **physical** growth and well-being,
- **cognitive** development, and
- **socio-emotional** development.

ECD policies and programs can directly affect these outcomes, and therefore benefit both individuals and societies.

Before continuing, it is also important to distinguish ECD programs from ECD policies. By "programs," we refer to specific interventions that may vary according to primary objective (e.g. improving physical growth and well-being, fostering cognitive or socio-emotional development), coverage (small scale, universal), and other program characteristics. In contrast, by "policy," we refer to the regulatory framework and institutional arrangements for service delivery at the national and/or state level to ensure that a nation's children have access to quality ECD services.

3. A Typology of ECD Programs

In order to compare the wide variety of ECD programs that exist in the region, it is useful to characterize them according to a set of main attributes. These key characteristics of ECD interventions include: (i) Primary policy objective; (ii) Brief description; (iii) Focus area/intervention mechanism; (iv) Coverage/access; (v) Institutional arrangements; (vi) Financing; (vii) Service providers; (viii) Quality assurance mechanisms; (ix) Challenges for going to scale and improving service delivery.

(i) **Primary policy objective**. Each ECD program should have a clear policy objective. Some examples include: getting young children school ready; providing nutritional supplementation to a specific population; ensuring parents receive parenting education to facilitate cognitive stimulation of infants.

(ii) **Brief description**. For each program, it is useful to present a brief description of its main characteristics.

(iii) **Focus area/intervention mechanism**. There are several important areas of focus of ECD interventions, including: health, nutrition, education, parenting practices, and poverty alleviation. Within these areas, there are also intervention mechanisms, such as milk or micronutrient supplements, early childhood care in centers and/or at home, preschool education, parenting education. An important dimension for classifying ECD programs is therefore the area of focus of the intervention.

(iv) **Coverage/access**. Programs vary in the extent to which various populations can access them, ranging from very low coverage to universal access.

(v) **Institutional arrangements**. Understanding the underlying institutional arrangements for the provision of ECD services is important. This includes policy setting, oversight (including monitoring and evaluation), and provision.

(vi) **Financing**. The funding available for ECD as well as the specific financing mechanisms employed to channel funds to programs and providers are important determinants to access, quality, equity and efficiency. Documenting the financing of ECD programs is also important for evaluating cost-effectiveness of alternative interventions.

(vii) **Service providers often include various government agencies at several levels of government (national, state, local), private sector providers, and community organizations**. For each program, it is important to understand who is responsible for its provision.

(viii) **Quality assurance mechanisms**. Research evidence indicates the important role that quality of ECD services plays in the effects of ECD programs on an individual's life outcomes. Understanding how different programs ensure quality is therefore critical. Quality assurance mechanisms range from establishing standards for service delivery, to supporting providers in meeting the standards and enforcing compliance.

(ix) **Challenges for going to scale and improving service delivery**. An important goal is for effective programs to be scaled up to reach all those young children who are eligible. This dimension refers to the challenges for going to scale and improving the quality of service delivery. Identifying these challenges is a necessary step toward then devising strategies to address them.

These characteristics are used to develop a categorization of ECD programs into four groups based on their primary policy objective, as follows:

- **Sectoral:** Provide a specific service to some or all children;
- **Cross-sectoral:** Provide some ECD services to some groups of children (can be specifically targeted to specific populations);
- **Multi-Sectoral:** Give children equal opportunities to reach their full potential in life; and
- **Comprehensive:** Ensure that all children reach their full potential in life.

Sectoral programs are typically independent interventions in specific sectors such as health or education, often led by government agencies or NGOs with low inter-institutional coordination. Examples of these include preschool education and nutritional supplements.

Cross-sectoral programs also are usually independent interventions in specific sectors but with some component from another sector, often led by government agencies or NGOs. Some Cross-sectoral programs involve large-scale interventions with strong political leadership, they are often targeted to vulnerable populations but require relatively low inter-agency coordination or integration across sectoral policies. Examples of these include school feeding programs.

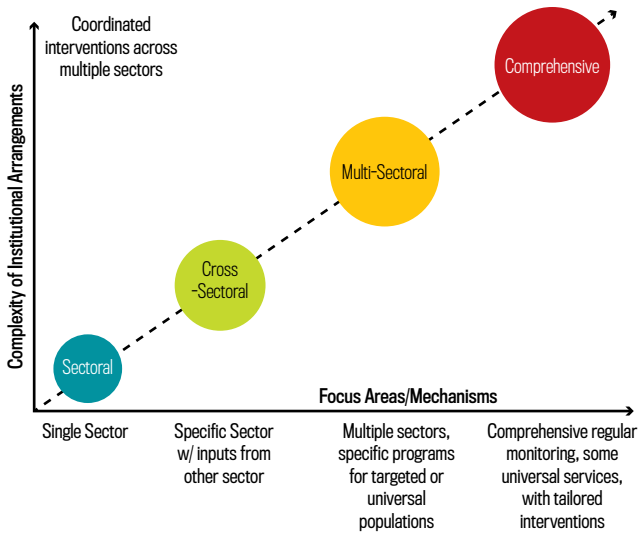
Multi-sectoral programs involve the implementation of multiple interventions in a coordinated way, where the focus is reaching children with systematic interventions during early childhood. They can vary in the degree of coverage, some being targeted to vulnerable populations while others universal in coverage. They require a high degree of inter-agency coordination.

Comprehensive programs are those with a comprehensive approach to ECD involving multi-sectoral interventions but tailored to each child, following individual ECD growth trajectories to ensure that all children receive adequate multi-sectoral support as needed. They require a high degree of inter-agency coordination and integration across sectoral policies.

Figure 1 graphically describes how these four categories of ECD programs differ in terms of focus areas and institutional arrangements.

In the Annex, we present a description of a diverse group of ECD programs in Latin America and the Caribbean and their classification into the four program categories. However, it is important to note that these categories represent a continuum of possible ECD interventions and that, therefore, some programs may not fall exactly within the description of one category. In these cases, we use our best judgment to classify them into one of the four categories, but recognize that improved information may affect this classification.[1]

Figure 1. Categories of ECD Programs: Focus Areas and Institutional Arrangements



Source: Authors.

1 For instance, an evaluation of program implementation and impact may imply that a specific sectoral program moves up from one category to another. As a result, some programs may be transitioning from, for example, "sectoral" to "cross-sectoral".

4. A Framework for Classifying ECD Policies

As mentioned in the Introduction, ECD programs differ from policies. Most of the empirical research has focused on evaluating the impact of specific ECD programs. Based on the convincing findings of the large impacts of investing in ECD, policy makers around the world, together with the international community, now face the challenge of how to devise effective ECD policies to ensure that all children reach their full potential. In this section, we propose an approach to contribute to this process. The approach relies on (i) taking stock of the ECD programs and interventions that already exist in a specific country; (ii) analyzing their main characteristics and classifying them into Sectoral, Cross-Sectoral, Multi-Sectoral, and Comprehensive; (iii) evaluating the level of development of ECD policies at the national and/or subnational level; and (iv) identifying country-specific policy options to strengthen ECD policies and programs. In Section 3, we described the key characteristics and classification criteria for ECD programs. In this section, we turn to how to evaluate the level of development of ECD policies at the national and/or subnational level. In the next section, we present case studies from three selected countries, where we carry out all four steps in the approach delineated herein.

The four critical dimensions of ECD policies at the national and or subnational level identified for the analysis include:

1. **Enabling** environment. This refers to: the existence of an adequate legal and regulatory framework to support early childhood development; the availability of adequate fiscal resources; and the degree of coordination within sectors and across institutions to ensure that services can be effectively delivered.

2. **Degree** of implementation. This refers to the extent of coverage (as a share of the eligible population) and gaps in coverage.

3. **Monitoring** and quality assurance. This refers to the development of standards for ECD services, the existence of systems to monitor compliance with those standards, as well as the implementation of systems to monitor ECD outcomes across children.

4. **Policy** focus. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, and social protection. An ECD approach involving multiple sectors is a critical policy dimension.

For each of these four dimensions, we evaluate the level of development of each country or system. These levels of development range from less developed (or "latent") to fully developed (or "mature"). Table 1 describes the characteristics of the different levels of development for each of the three ECD policy dimensions.

As Table 1 suggests, in an ideal situation, ECD policies in a country would be in the "mature" column for all three dimensions. In such an ideal situation, the country would have: (i) a solid legal framework for ECD, sustained financing for attaining ECD goals, and a high degree of inter-institutional coordination; (ii) universal coverage in key ECD services, such as maternal and child health and preschool education, information on ECD outcomes at individual, national, regional, and local levels; (iii) quality standards are well defined for all sectors, and all young children's individual needs are monitored and met; and (iv) integrated services for all young children, some universally provided, others tailored to young children's unique needs.

Table 2 delineates, for each ECD policy dimension, the key variables and how they would be observed at each level of development. While the "mature" column represents the ideal, a country with an "established" level of development in the key ECD dimensions indicates a developed policy framework in a majority of sectors, adequate implementation, and multi-sectoral approaches to ECD.

A "mature" level of ECD policy development is attainable in the medium- and long-term. In the meantime, one can identify the key dimensions where each country is falling behind this ideal and develop strategies to address those. This exercise is, by definition, country-specific and should be country-led. In the near future, we plan to develop instruments to facilitate the diagnosis of each country's level of development regarding ECD Policies and Programs.

To illustrate how this exercise may be relevant to policy makers in Latin America and the Caribbean, in the next section we illustrate its application to three country cases – Colombia, Panama and Chile –, which are at different levels of development with respect to their ECD policies.

Table 1. ECD Policy Dimensions and Levels of Development

ECD Policy Dimensions	Level of Development			
	Latent	Emerging	Established	Mature
Enabling Environment	Legal framework non-existent, ad-hoc financing, few institutions, low within sector coordination, low inter-institutional coordination.	Minimal legal framework, a few programs with sustained financing, low inter-institutional coordination, higher within-sector coordination.	ECD regulations in some sectors, many programs with sustained financing, functioning intra- and inter-institutional coordination.	Developed legal framework for ECD, sustained financing for attaining ECD goals, inter-institutional coordination.
Degree of Implementation	Low coverage, pilot programs.	Coverage expanding but important gaps remain; some established programs in few sectors; high inequality in access.	Near-universal coverage or universal in some sectors; established programs in several sectors, low inequality in access.	Universal coverage in ECD, with comprehensive strategies across sectors.
Monitoring and Quality Assurance	Limited standards exist for the provision of ECD services; only minimal measures of infant & child mortality are reported.	Standards for ECD services exist for at least some sectors, but there is no system to regularly monitor compliance; increased information on ECD outcomes at the national level.	Standards for ECD services exist for most or all sectors; a system is in place to regularly monitor compliance; information on ECD outcomes at national, regional, and local levels.	Standards for ECD services exist for most or all sectors; a system is in place to regularly monitor and enforce compliance; information on ECD outcomes at individual, national, regional, and local levels, all young children's individual needs are monitored and met.
Policy Focus	Some health, nutrition, education, and infant/child protection services, but minimal and without coordination.	Some health, nutrition, education, and infant/child protection services.	Health, nutrition, education, and infant/child protection services well established.	Integrated services for all children, some universally provided, others tailored to young children's unique needs.

Source: Authors.

Table 2. ECD Policy Dimensions, Variables and Levels of Development

ECD Policy Dimensions	Variables	Level of Development			
		Latent	Emerging	Established	Mature
Enabling Environment	Legal framework	non existent	minimal	regulations in some sectors	developed
	Coordination	low within sector	high within sector	low inter-institutional	high inter-institutional
	Financing	ad hoc	some programs with sustained	many programs with sustained	sustained for attaining goals
Degree of Implementation	Coverage	low	expanding	universal in some sectors	universal in ECD
	Programs	pilot	established in few sectors	established in several sectors	established in ECD
Monitoring and Quality Assurance	ECD Information	minimal measures	outcomes at national level	outcomes at national, regional, local level	outcomes at national, regional, local & individual level
	Quality Standards & Compliance	Limited or no standards	Standards in some sectors	Standards in most sectors, compliance is monitored regularly	Standards in all sectors, compliance is regularly monitored and enforced
Policy Focus	ECD Interventions (health, nutrition, education & child protection)	some and minimal	some established	well established services	integrated services universally provided

Source: Authors.

5. Identifying Options for Strengthening ECD Services at the Country Level: Case Studies of Colombia, Panama, and Chile

In this section, we apply the conceptual frameworks described above to three Latin American countries: Colombia, Panama, and Chile. These countries were selected because of their interest in expanding ECD and also because they are at different stages of development in terms of ECD policy. Specifically, we:

1. **Take** stock of the main ECD interventions in each country and use the typology of ECD programs introduced in Section 3 to categorize them into sectoral, cross-sectoral, multi-sectoral or comprehensive; and

2. **Use** the framework for classifying ECD policies discussed in Section 4 to identify, for each country, its current level of development in this area and some policy options to strengthen its ECD policies.

Table 3 summarizes the levels of development for each ECD policy dimension in Colombia, Panama, and Chile. In the next three sections, we describe in detail the ECD programs and policies in these countries, from which this benchmarking is derived.

Table 3. Benchmarking ECD Policy Dimensions and Levels of Development in Colombia, Panama, and Chile

ECD Policy Dimensions	Variables	Level of Development		
		Colombia	Panama	Chile
Enabling Environment	Legal framework	Established	Emerging	Established
	Coordination	Established	Emerging	Established
	Financing	Established	Latent	Established
Degree of Implementation	Coverage	Emerging	Latent	Established
	Programs	Established	Emerging	Established
Monitoring and Quality Assurance	ECD information	Emerging	Emerging	Emerging
	Quality standards and compliance	Established	Latent	Emerging
Policy Focus	ECD interventions (health, nutrition, education & child protection)	Established	Emerging	Mature

Source: Authors.

I. Colombia

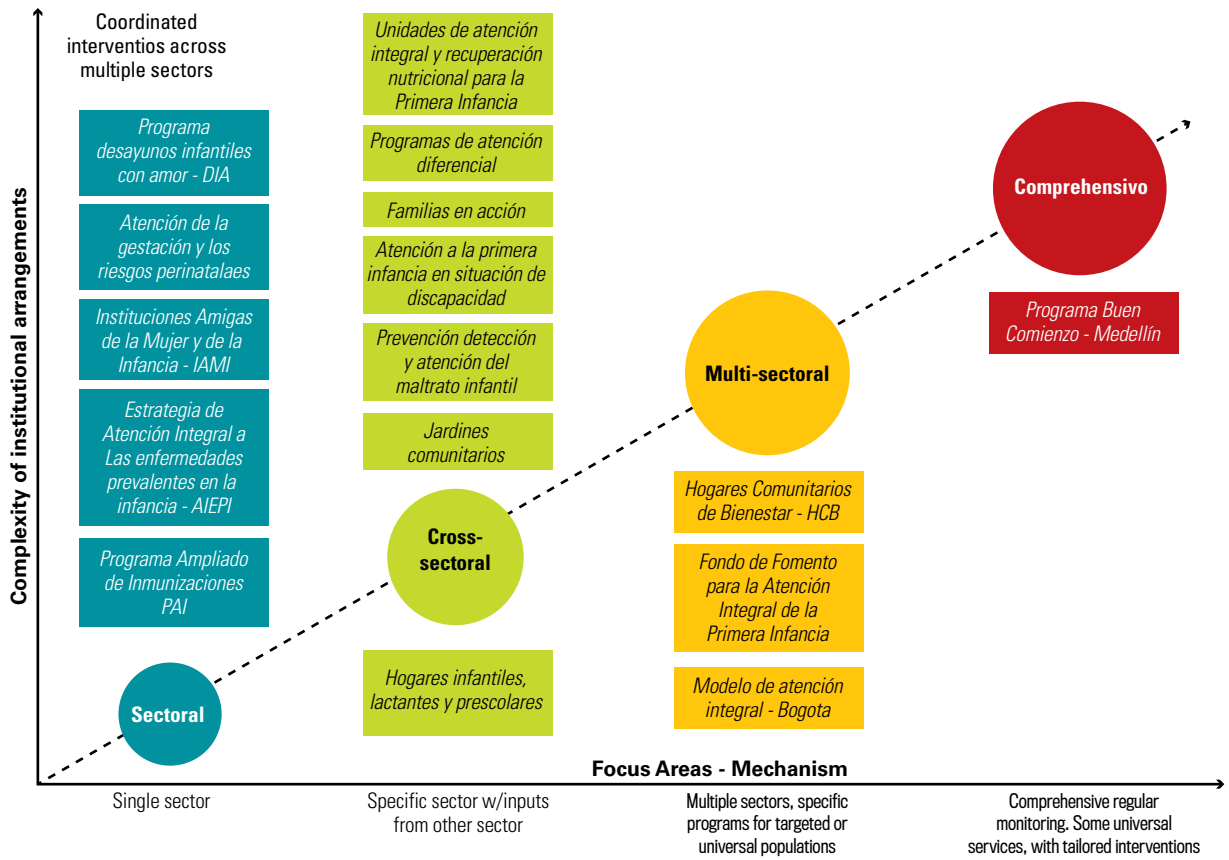
Colombia is a country with approximately 46 million people, of which some 4.38 million are aged five or younger.2 Over the last number of decades the country has made a concerted effort to improve the lives of young children through the establishment of legal rights, increased investment and the provision of ECD services for health, nutrition, education, and child protection. These efforts have shown positive impacts on ECD objectives and have contributed to the decrease in the child mortality rate for children less than five years of age from 35 per thousand births in 1990 to 20 per thousand births in 2007. Despite the numerous improvements, it is important to note that the situation remains dire for many children in Colombia. Approximately 15% of children in Colombia are living under the international poverty line of US $1.25 per day. In 2008 (the latest year for which data are available), the gross enrollment rate in pre-primary education in Colombia was 49 percent (World Bank EdStats).

(a) ECD Programs in Colombia

At present, there are numerous ECD programs at the national, state, and municipal levels in Colombia. According to the typology introduced in Section 3, these programs include sectoral, cross-sectoral, multi-sectoral and comprehensive interventions.

Table 4 categorizes selected ECD interventions in Colombia. It is important to note that this is simply a snapshot of the numerous interventions that are operational in the country. These interventions were selected due to their relevance and information availability.

Figure 2. Inventory of ECD Programs in Colombia, by Type



Source: Authors.

2 While our definition of ECD includes ages 0 to 6, data for Colombia were available only up to age 5.

Table 4. Categorization of Selected ECD Programs in Colombia

ECD Intervention	Desayunos infantiles con amor (DIA)	Programa Ampliado de Inmunizaciones (PAI)	Hogares Comunitarios de Bienestar (HCB)
Classification	**Sectoral**	**Sectoral**	**Multi-Sectoral**
Primary policy objective	The primary objective of *Desayunos infantiles con amor* (Breakfasts with Love for Children) is to help improve the nutrition of children between six months and five years of age who belong to level one and two of SISBEN (Potential Beneficiaries of Social Programs Identification System) by providing breakfast to supplement their daily diet.	The *Programa Ampliado de Inmunizaciones* (Expanded Program on Inmunization) is in charge of the elimination, eradication and control of preventable diseases in Colombia, in order to reduce mortality and morbidity caused by these diseases in the population under the age of six.	The *Hogares Comunitarios de Bienestar* (Community Homes for Well-being) program aims to attend to the basic needs of the most marginalized children below the age of six with respect to affection, nutrition, health, protection, and psychosocial development.
Brief description	This program is a measure taken by the ICBF (Colombia Family Welfare Institute) to provide nutritional supplements to the most marginalized children during their crucial years of development. Auxiliary benefits of the program include the promotion of children's affiliation to the general social security system in health and the improved participation and synergy within communities due to the program activities.	The *PAI* was originally created by the WHO in 1974 and adopted in the Region of the Americas in 1977. During the following year the program was established in Colombia to provide access to all children from birth to the age of five and other target populations with immunizations against prevalent diseases.	In 1986 the ICBF established, and the CONPES (National Council for Economic and Social Policy) approved, the *HCB* program as a "human development strategy and a new conception of holistic assistance in order to provide coverage to the poorest childhood population in urban zones and rural centers".
Focus areas/ intervention mechanisms	The nutritional component of the program is implemented using two types of breakfast: Breakfast One and Breakfast Two. Breakfast One only provides the program's nutritional protein powder (called *Bienestarina*), while Breakfast Two, which the vast majority of beneficiaries receive, includes whole milk, a solid base cereal and traditional *Bienestarina*.	In 1978 the program provided vaccinations for tuberculosis, poliomyelitis, diphtheria, pertussis, neonatal tetanus, and measles. The program has since expanded to include vaccinations for hepatitis B, rubella, mumps, influenza and yellow fever. The vaccinations are provided for free and are compulsory for the target population.	The initial *HCB* model consisted of community family homes led by community mothers who cared for 13-15 children. The program has expanded to include community group homes; community multiple homes; homes sponsored by companies; and family, women, and children's homes. As of 2005 the community family homes accounted for more than 75% of *HCB* assistance.
Coverage/ access	The program is designed to reach the population in both rural and urban areas. In total, *DIA* provides breakfast to 1,228,641 children annually, across 1,045 municipalities.	The program provides coverage to children under the age of six and to women in reproductive age and others in vulnerable locations. The objective is to have at least 95% of the target population vaccinated. In 2006 coverage was provided for approximately 90% of the 929,630 children under the age of one.	The program targets families classified in levels 1 and 2 of SISBEN. The *HCB* program has the greatest coverage among programs for young children in Colombia, and served approximately 1,200,000 children in 2008.
Institutional arrangements	*DIA* is operated by the ICBF. An operational manual is used to explain the program, goals and target population. The manual also defines the responsibilities of institutional and sectoral actors as well as community volunteer and support groups.	The programs operations are governed by the Social Security Reform Act (Law 100 of 1993) and involve political and administrative authorities at the national and sub-national levels, as well as both public and private insurers and providers. The Ministry of Social Protection defines the national immunization policy and standards. Districts, decentralized municipalities, and departments are in charge of ensuring the availability of vaccination services, and supervising and promoting the delivery of services.	The *HCB* program is operated by the ICBF. In 1988, the program's legal basis was strengthened when the government enacted Law 89 which increased ICBF revenues to assure expansion of the program's coverage. The ICBF is responsible for intervention design and execution, excluding devising the requirements for location, space and infrastructure for the various homes.
Financing/ cost-effectiveness	The program is funded by the ICBF and had annual expenditures of $144 million pesos in 2009. This marks a substantial increase from the programs' 2002 budget of $1.744 million pesos.	The program is funded by the IDB and the Government of Colombia. In 2006 the program had a budget of $99.321 million pesos. The Ministry of Social Protection is responsible for managing and appropriating program resources.	In 2009 the *ICBF* reported that the *HCB* program received income from the 3% payroll tax in the amount of US $760.789 million pesos, and the annual per child cost was approximately US $350.

ECD Intervention	Desayunos infantiles con amor (DIA)	Programa Ampliado de Inmunizaciones (PAI)	Hogares Comunitarios de Bienestar (HCB)
Service providers	The breakfasts are delivered each month to one of over 9,000 centers in the country. Deliveries are made each month and are regulated by the program's "Delivery Act".	The Ministry of Social Protection operates the program and distributes the vaccines. Under the terms of Law 100, sub-national units are responsible for direct health service delivery.	Community mothers are the executors of the *HCB* program. They are trained in development, child health and nutrition, organization, and scheduling of activities, and are financially compensated for their efforts. In general, community mothers work for 8 hours per day and provide meals for children during this time. Approximately 70% of community mothers are located in urban zones, and the remaining 30% in rural zones. The *HCB* program provides educational and household materials for community mothers.
Quality assurance mechanisms	The ICBF and an externally contracted agency are responsibly conducting extensive program monitoring and evaluations. Furthermore, the beneficiary families are crucial components of the quality assurance mechanism. Authorities must be contacted in the instance that the program is being used in any type of commercial manner or for electoral purposes.	The National Health System (INS) is responsible for epidemiological surveillance and the public health laboratory. The *PAI* and the Office of the Superintendent for Health Services are responsible for overseeing the program's output. Official vaccination rates are computed at the municipal level and submitted to the National Health Institute, which aggregates the information and calculates the national coverage rate. In addition, the IDB undertakes monitoring and evaluation of implementation of the Strengthening the Expanded Program on Immunization 2005 - 2008 initiative.	The ICBF uses monitoring information for program supervision and to ensure follow-up processes occur. Evaluation activities focus on areas such as program impacts, quality standards, contents and materials, and the implementation process. Since inception, the Government of Colombia has undertaken two exhaustive studies of the program. In addition, numerous other organizations, research institutes and universities have conducted studies on the program.
Challenges for going to scale and improving service delivery	One of the larger challenges encountered by this program is the timely and consistent delivery of supplements. Going forward, expanded financial resources will be required to increase coverage.	A major challenge in attaining increased coverage are sharp geographical and demographic inequities in vaccination levels. Vaccination coverage in the poorer, remote municipalities is far below national or departmental averages.	An area for improvement are the requirements for community mothers. Community mothers in rural areas are less likely to have completed elementary and high school, and very few have attended post-secondary education.
Institutional arrangements	DIA is operated by the ICBF. An operational manual is used to explain the program, goals and target population. The manual also defines the responsibilities of institutional and sectoral actors as well as community volunteer and support groups.	The programs operations are governed by the Social Security Reform Act (Law 100 of 1993) and involve political and administrative authorities at the national and sub-national levels, as well as both public and private insurers and providers. The Ministry of Social Protection defines the national immunization policy and standards. Districts, decentralized municipalities, and departments are in charge of ensuring the availability of vaccination services, and supervising and promoting the delivery of services.	The HCB program is operated by the ICBF. In 1988, the program's legal basis was strengthened when the government enacted Law 89 which increased ICBF revenues to assure expansion of the program's coverage. The ICBF is responsible for intervention design and execution, excluding devising the requirements for location, space and infrastructure for the various homes.
Financing/ cost-effectiveness	The program is funded by the ICBF and had annual expenditures of $144 million pesos in 2009. This marks a substantial increase from the programs' 2002 budget of $1.744 million pesos.	The program is funded by the IDB and the Government of Colombia. In 2006 the program had a budget of $99.321 million pesos. The Ministry of Social Protection is responsible for managing and appropriating program resources.	In 2009 the ICBF reported that the HCB program received income from the 3% payroll tax in the amount of US $760.789 million pesos, and the annual per child cost was approximately US $350.

ECD Intervention	Desayunos infantiles con amor (DIA)	Programa Ampliado de Inmunizaciones (PAI)	Hogares Comunitarios de Bienestar (HCB)
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Quality assurance mechanisms	The ICBF and an externally contracted agency are responsibly conducting extensive program monitoring and evaluations. Furthermore, the beneficiary families are crucial components of the quality assurance mechanism. Authorities must be contacted in the instance that the program is being used in any type of commercial manner or for electoral purposes.	The National Health System (INS) is responsible for epidemiological surveillance and the public health laboratory. The PAI and the Office of the Superintendent for Health Services are responsible for overseeing the program's output. Official vaccination rates are computed at the municipal level and submitted to the National Health Institute, which aggregates the information and calculates the national coverage rate. In addition, the IDB undertakes monitoring and evaluation of implementation of the Strengthening the Expanded Program on Immunization 2005 - 2008 initiative.	The ICBF uses monitoring information for program supervision and to ensure follow-up processes occur. Evaluation activities focus on areas such as program impacts, quality standards, contents and materials, and the implementation process. Since inception, the Government of Colombia has undertaken two exhaustive studies of the program. In addition, numerous other organizations, research institutes and universities have conducted studies on the program.
Challenges for going to scale and improving service delivery	One of the larger challenges encountered by this program is the timely and consistent delivery of supplements. Going forward, expanded financial resources will be required to increase coverage.	A major challenge in attaining increased coverage are sharp geographical and demographic inequities in vaccination levels. Vaccination coverage in the poorer, remote municipalities is far below national or departmental averages.	An area for improvement are the requirements for community mothers. Community mothers in rural areas are less likely to have completed elementary and high school, and very few have attended post-secondary education.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

Table 5. Categorization of Selected ECD Programs in Colombia

ECD Intervention	Familias en Acción	Instituto Colombiano de Bienestar Familiar (ICBF)
Classification	**Cross-Sectoral**	**Multi-Sectoral**
Primary policy objective	*Familias en Acción* (Families in Action) aims to complement family income to increase spending on food; improve children's health outcomes by ensuring access to regular healthcare; and improve childcare practices in terms of health, nutrition, and early stimulation.	The *ICBF* (Colombia Family Welfare Institute) is a national entity for coordinating Colombian policies for family welfare. A large component is guaranteeing the rights, protection and well being of children and their families through extensive ECD interventions.
Brief description	Founded in 1999, *Familias en Acción* is a conditional cash transfer (CCT) program that targets pregnant women and mothers with children less than 7 years of age who are living in poverty, with a particular focus on displaced and indigenous families. The program uses a combined parent and child strategy to deliver ECD services to the targeted population.	The *ICBF* is a semi-autonomous institute under the Ministry of Social Protection. The *ICBF* was established in 1968 in response to problems such as nutritional deficiency, disintegration and instability of families, loss of values, and abandoned children. Since 1974, the *ICBF* has implemented and supported various modalities of assistance for young children through integrated programs of care, nutritional support, preventive health, and socio-affective development. In 1986, the *ICBF* established a very important program called *Hogares Communitarios* to serve pregnant women and children from birth to five years of age, contribute to the eradication of poverty, and expand service coverage for working parents and vulnerable children.
Focus areas/ intervention mechanisms	The intervention utilizes "community mother leaders," who guide assemblies of participating mothers. Childcare and family workshops cover topics of literacy, health, nutrition, hygiene, contraception, child development and play. The program is tailored to the various cultural identities of the regions and communities by incorporating ritual elements and promoting learning play. Receipt of cash transfers and nutritional supplements by families are conditioned with respect to children's use of health services, such as immunizations and controls regarding physical growth and development.	The *ICBF* has a number of programs and services tailored to family, ECD, adolescents between 7 and 17 years of age; older adults; and children with violated rights. Some of these include family education, children homes, help to pregnant women and nursing mothers, pre-youth and youth clubs, various nutritional assistance programs, and specific programs for children with special needs.
Coverage/access	*Familias en Acción* has become national on scale covering all of the 32 departments and 1,093 of the 1,098 Colombian municipalities. The goal for annual coverage is: 1,500,000 families (600,000 urban and 900,000 rural) living in severe poverty. This includes 500,000 and 745,000 children living in urban and rural locations, respectively.	The *ICBF* is present in each of the departmental capitals and has 203 centers dispersed throughout the country. These centers are effective in providing closer and participative attention to children, adults and families of the urban, rural, native and Afro-Colombians. Approximately 10 million Colombians benefit from the *ICBF* services.
Institutional arrangements	*Familias en Acción* has not developed a strong legal basis. The program is located in the Directorate of Presidential Programs within the Presidential Agency for Social Action and International Cooperation. Sectoral support is received from both the MoE and the MoH. municipalities play a crucial role in the implementation of the program. In order to participate, each municipality must sign a legal document that outlines the various responsibilities of the mayoral offices. Failure to comply can result in temporary or permanent suspension of *Familias en Acción*.	The *ICBF* was transferred from its former placement under the MoH to the Ministry of Social Protection (which now also includes the MoH). The *ICBF* has an independent board of directors and head of the institution.
Financing/cost-effectiveness	Beneficiary families receive US $50 per month. Program funding uses a two-pronged approach: the Government of Colombia (Presidency and the National Treasury) and international donors, namely the World Bank and IDB. Administrative costs are an estimated 3% of the annual budget.	The *ICBF* has obtained partial autonomy through extensive funding support from a national 3% payroll tax that is mandated by a series of national laws, accords and decrees. Communities, NGOs, and workers' cooperatives also contribute to the program, but the amounts are not publicly reported. In addition, the *ICBF* receives grants and contracts from national and international sources in the amount of approximately US $25 million annually for special projects. The *ICBF* allocates funds to each respective intervention.

ECD Intervention	Familias en Acción	Instituto Colombiano de Bienestar Familiar (ICBF)
Service providers	The provision of services uses a joint public and private approach. The CCT component is provided by the Government of Colombia. The expansion of the program has necessitated additional technical support people at regional levels called *Enlace Municipal* (Municipal Liaison). Participating municipalities are responsible to pay the salaries of these individuals. As at the end of 2007, 1,090 were expected to be trained and in place. In addition, "community mother leaders" are private service providers.	The *ICBF* services are provided through its various interventions (listed above). The direct service provider depends on the type of intervention and targeted population. For instance, the *ICBF* implements the *Hogares Comunitarios* program directly, through contractors, and with the help of other programs of the national system for family welfare; communities throughout Colombia, and Parents' Associations support each community home.
Quality assurance mechanisms	The intervention is monitored on a quarterly, semester and annual basis. Monitoring is conducted by professional evaluators, other program professionals, and the program director. They look at various intervention elements including the program structure, participants, implementation process, contents, and materials and methods. An extensive evaluation process is undertaken each quarter and semester by participants, professional evaluators, external evaluators, and the program director, to ensure program quality and effectiveness.	The *ICBF* conducts monitoring and evaluation activities for its interventions. For example, with *Hogares Comunitarios*, the *ICBF* uses monitoring information for program supervision and to ensure follow-up processes occur. Evaluation activities focus on areas such as program impacts, quality standards, contents and materials, and the implementation process.
Challenges for going to scale and improving service delivery	Funding is reported to be fungible and lacking stability. In terms of effects, intervention has been found to be helpful in achieving improved nutrition and health outcomes, however unable to make major impacts on child cognitive development and school readiness. This could be due to differential quality in the components devoted to early child stimulation.	The *ICBF* reports that a major limitation is the availability of resources for the expansion of program coverage. The *ICBF* continues to work to develop new and innovative approaches to serve vulnerable populations.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

(a) Classification of ECD Policies in Colombia

Taking stock of ECD interventions is useful to map the landscape. However, the policy framework is critical for ensuring access, quality and equity of ECD services. As Table 6 shows, based on an analysis of Colombia's ECD policies and programs, we observe that its Enabling Environment and Policy Focus are in the Established stage, while the Degree of Implementation is in the Emerging stage, according to the Framework presented in Section 4.

(b) Policy Options to Strengthen ECD Policies and Programs in Colombia

Colombia has made important strides toward strengthening its ECD policy framework, and numerous programs offering ECD services exist. However, important challenges remain, including expanding coverage of ECD services and achieving full implementation of Act 1295.

As a first natural step, Colombia should focus on identifying gaps in coverage and reaching the excluded populations. Simultaneously, it will be important to further develop the level of coordination and synergy amongst service providers and government agencies. In the near future, Colombia should develop instruments to monitor individual children's developmental pathways to ensure a comprehensive approach to ECD for all children.

Table 6. Classification of ECD Policies in Colombia

ECD Policy Dimensions		Description
Enabling Environment	Established	The perspective of the rights of children is based legally in the International Convention on the Rights of the Child (1989), ratified by Colombia in 1991. The Constitution provides the legal foundation for the comprehensive rights of children with Article 44, which establishes the basic rights of children; and Article 50, which entitles free health care to all children under the age of one that are not covered by any type of protection or social security. The Code of Children and Adolescents (Law 1098 of 2006) specifies the importance of the life cycle within human development and determines the right to personal development in early childhood, including health care and nutrition, vaccinations for disease, early education and protection against physical hazards. In 2007, the National Policy for Early Childhood (Política Pública Nacional de Primera Infancia) was adopted with the aim to: promote the integral development of children from gestation up to six years of age, respond to their specific needs and characteristics, and contribute to the achievement of equity and social inclusion in Colombia. The Ministry of Social Protection, ICBF and MoE are integral members. Both individually and in conjunction, these institutions operate numerous ECD interventions. In general, financing requirements for these programs can be considered adequate for developing and maintaining services. The ICBF is financed with receipt of 3% of the national payroll tax. The latest development of ECD in Colombia is Act 1295 (2009). The act indicates that the purpose of the state is to contribute to improving the quality of life of expectant mothers and children under the age of six, and directs attention to the need to develop a comprehensive system of care for infants that goes beyond the programs in place.
Degree of Implementation	Emerging	The institutional framework for the National Policy for Early Education consists of three bodies, one national and two regional. The national body is tasked with centrally designing and managing the program, and one regional body promotes inter-sectoral and interagency coordination while the other manages resources and guides the formulation of the Comprehensive Care Plan and its implementation at the local level. This approach enables gathering and distribution of ECD information at all levels. High levels of coverage have been achieved through the numerous ECD interventions in health, nutrition, education, and child protection. Many of these programs are entrenched throughout the country, including difficult to reach municipalities and the most marginalized regions. High levels of inequality persist amongst ECD aged children.
Monitoring and Quality Assurance	Emerging	Colombia has quality assurance mechanisms that span sectors and institutes, in addition to those that are specific to interventions. Together, these mechanisms provide a framework to enforce compliance with ECD quality standards and to provide the necessary support so that it is possible to meet these standards. A key component in monitoring the efficacy of ECD interventions is the Quality of Life Survey (Encuesta de Calidad de Vida). In 2003 the survey was expanded to include variables that relate, and therefore help monitor, the HCB (Hogares Comunitarios de Bienestar) program. The ICBF has various mechanisms to ensure quality across its range of services. For one, the ICBF has established a system for supervising contracts with contributors and the units providing services to ensure fair, responsible transactions. For the institution's largest ECD program, HCB, two full-scale evaluations (1996 and 2006) have been undertaken. The first provided a strategy for improving the HCB program and the second was an exhaustive review of the program's primary aims and organization structure. In 2008 the Government of Colombia and the World Bank commenced a $15.8 million partnership aimed at strengthening the country's monitoring and evaluation system. The investment encompasses the various levels of government and institutions, and through these has a direct impact on ECD quality assurance. Collectively, the objective is to ensure the availability and production of quality information for program and policy design, to provide more information in order to make better-informed investment decisions, and to establish effective monitoring and evaluation capabilities at local and regional levels.
Policy Focus	Established	Tables 4 and 5 above provide examples of interventions in health, nutrition, education, and child protection. A number of these programs have a single focus while others are more expansive and provide services in multiple areas such as health, nutrition and child protection. The level of inter-sectoral and interagency coordination has improved in recent years, providing a more collaborative approach to ECD. This achievement is in large part due to the creation of the National Policy for Early Childhood and, more recently, Act 1295. It appears that the country is prepared to develop a comprehensive system of care. To accomplish this it will be important to further develop the level of coordination and synergy amongst institutions and government.

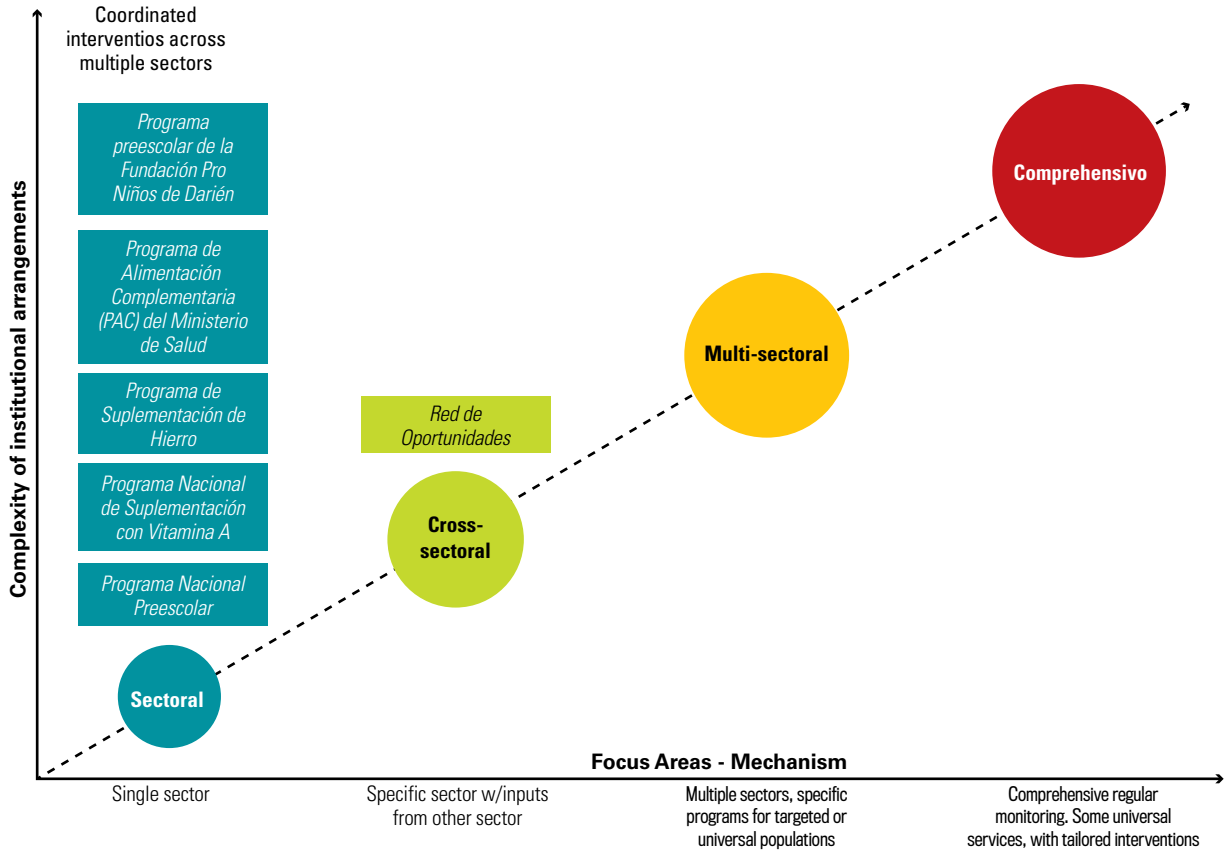
II. Panama

Panama is a small nation with 3,504,483 people, of which 420,324 are under the age of five. Despite the country's high income per capita compared with other countries in the region, high inequalities exist among the rich and poor. In 2008, nearly 33% of the population was living below the poverty line, which is valued at $3.13 per day. Furthermore, 14.4% of the population was living in extreme poverty, or on less than $1.77 per day. A large portion of these individuals are indigenous. During the last six years this age group has experienced an increase in chronic malnutrition.

(a) ECD Programs in Panama

Panama has numerous ECD programs in nutrition, health, education and development. The following section presents six. It is important to note that this is not a comprehensive list of all ECD programs, but rather an exercise to highlight some of the most important. This will provide the reader with a good understanding of ECD in Panama, what achievements have been reached, and where improvements can be made. In addition to interventions operated by ministries, private organizations and foundations are prominent. One such example is presented in the following tables. Two programs not depicted below are the Programa de Alimentación Complementaria Escolar (PACE, School Complementary Food Program), which is operated by the MoE, and Bono Familiar para la Compra de Alimentos (Family Bond for Food Purchase), which is a program initiated in 2005 by SENAPAN (Plan for Food and Nutritional Security) with contributions from the MoH, MoE, Ministry of Social Development, and Ministry of Agriculture, among others. Figure 3 presents the ECD interventions in Panama according to the typology discussed in Section 3. These interventions' characteristics are described in Tables 7 and 8.

Figure 3. ECD Programs in Panama, by Type



Source: Authors.

Table 7. Categorization of Selected ECD Programs in Panama

ECD Intervention	Programa de Alimentación Complementaria (PAC) del Ministerio de Salud	Programa de Suplementación con Hierro	Programa Nacional de Suplementación con Vitamina A
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Primary policy objective	The *Programa de Alimentación Complementaria* (Complementary Food Program) distributes fortified foods to improve the nutritional status of children under five, pregnant women, nursing mothers, and tuberculosis patients.	The *Programa de Suplementación de Hierro* (Iron Supplementation Program) aims to correct and prevent iron deficiency in children, women of childbearing age, and pregnant and lactating women.	The primary objective of the *Programa de Suplementación con Vitamina A* (Vitamin A Supplementation Program) is to improve maternal and child survival in areas of extreme poverty by providing Vitamin A supplements.
Brief description	Since 1995 the program has been implemented throughout Panama and ensures the adequate intake of calories for children. Compared with international standards, its energy content is lower than recommended due to the high prevalence of obesity in the country in both adults and children.	Iron deficiency is the most prevalent nutritional deficiency and the main cause of anemia worldwide. Since 1998 the *Programa de Suplementación de Hierro* has been operating to lower the high prevalence of anemia in Panama.	The national survey of Vitamin A deficiency among preschool children indicates that 1.8% of children aged 12 to 59 months are considered deficient. This figure is low enough not to be considered a public health problem; however, the prevalence among indigenous populations of the same age group is 23%.
Focus areas/ intervention mechanisms	The program distributes *Nutricereal*, which is a corn-based supplement high in calories (180) and protein (6 grams), and is fortified with vitamins and minerals. The size of each portion is 45 grams.	The iron supplement is distributed in drops, syrups or tablets. Infants of low birth weight receive 10 mg per day; children aged 4-11 months one mg per day; children aged 12-23 months receive 30 mg per week; children 6-11 years and women of reproductive age receive 60 mg and 400 mcg folic acid once a week; and pregnant and lactating women receive 60 mg and 400 mcg folic acid per day.	The administration of doses of Vitamin A is as follows: children aged 6-11 months receive one 100,000 IU dosage; children aged 1 to 5 receive two 200,000 IU dosages per year (one every six months); and lactating women receive one 200,000 IU dosage.
Coverage/access	The program is intended for children under the age of five, and pregnant and lactating women, with a particular focus on priority districts and children with low birth weight. According to estimates from the MoH, the program served 123,185 children under five years of age, and 26,072 pregnant and lactating women in 2009.	Beneficiaries of this program are children and pregnant women who are classified as poor and usually do not have access to social security. The MoH reported coverage of 43,000 children aged 12 to 23 months, 150,000 between 24 and 59 months, and 25,000 pregnant and lactating women in 2006.	In 2004 the program reported coverage for approximately 90,000 children and women, of which 16.4% of the population aged 6 to 59 months received coverage. Particular focus is on indigenous peoples.
Institutional arrangements	The MoH is responsible for program operations, and the Department of Nutrition is responsible for the development of the supplements.	The MoH is responsible for administering, operating and delivering the program.	The MoH is in charge of program design, operations, and delivery.
Financing/cost-effectiveness	The *PAC* is funded by the National Government and implemented by the MoH. In 2007-2008 the program had a budget of US $5 million.	The MoH reported a budget of US $813,336 in 2007.	The program is funded by the National Government and implemented by the MoH. The MoH reports that the annual cost for each child aged 4 to 11 months is US $.02 and US $.04 for each child aged one to four.
Service providers	The delivery of the food is determined by the MoH and made to health centers throughout the country.	The MoH is responsible for the distribution of iron and folic acid through its facilities.	Administration of Vitamin A takes places at premises determined by the MoH. These include urban and remote facilities in rural areas. UNICEF assists with the acquisition of megadoses of Vitamin A.

ECD Intervention	Programa de Alimentación Complementaria (PAC) del Ministerio de Salud	Programa de Suplementación con Hierro	Programa Nacional de Suplementación con Vitamina A
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Quality assurance mechanisms	Evaluations in 2001 with support from UNICEF, and in 2005 under the leadership of SENAPAN, have found that the program is well targeted and that better nutritional outcomes are observed in smaller families and for children with mothers who have higher education. The Department of Nutrition and MoH are responsible for quality control and program operations, respectively.	The MoH is tasked with monitoring and evaluating the program. In conjunction with UNICEF, studies have been undertaken to monitor and assess the state of iron deficiency and anemia in Panama (with the most recent occurring in 2006). Evaluations have found that the program is effective in reaching its recipients.	The MoH is tasked with ensuring program quality. Program monitoring includes logging registrants and the distribution of Vitamin A supplements. Evaluations are ongoing to ensure accuracy in targeting. The national survey of Vitamin A deficiency tracks prevalence. No exhaustive impact assessment of the program has been undertaken.
Challenges for going to scale and improving service delivery	Incidence of dilution within families limits the effectiveness of programs. It is imperative that the designated beneficiary receives the nutritional supplement.	Reports indicate that at times during the year the program experienced shortages, especially in drops and syrups for children under the age of five.	Since inception in 1992 the program has successfully expanded its coverage. The focus should be on the continued sustainable provision of services to high priority populations, and in particular indigenous populations.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

Table 8. Classification of Selected ECD Programs in Panama

ECD Intervention	National Preschool Program	Red de Oportunidades	Programa Preescolar de la Fundación Pro Niños de Darién
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Primary policy objective	The objective of Panama's *National Preschool Program* is to provide compulsory education to children aged four and five.	The *Red de Oportunidades* (Oportunity Network) aims to reduce critical poverty and enhance human capital through a cross-sectoral approach that links improved services with conditional cash transfers (CCT) to families in critical poverty.	*Programa Preescolar* (Preschool Program) is a complementary feeding program that contributes to improving the health and nutritional status of children aged 6-59 months in communities across the province of Darién.
Brief description	A collection of free public schools and private institutions that charge fees supply education to students. During the 1990's there was a boom in preschool education in public schools (kindergartens, COIF), and the creation of non-formal education programs (CEFACEI and *Educación Inicial en el Hogar*).	*Red de Oportunidades* was started in 2005 and is a national project as part of the development strategy to combat extreme poverty. It has the highest coverage among all social programs in the country.	In 1993 the *Fundación Pro Niños de Darién* (Foundation for Darién's Children) was founded with the objective of reducing malnutrition in children by implementing interventions in the areas of nutrition, health, education, and community development. The *Programa Preescolar* was started in 1993.
Focus areas/ intervention mechanisms	Educational services are offered Monday through Friday for a period of 10 months. The services are offered in urban, peri-urban, and rural areas, and indigenous communities. In 2005 there was an average of 20 students per teacher, and 95% of teachers were female.	The CCT component disburses cash to the heads of households to spend on basic needs. In order to qualify, families are required to fulfill specific "co-responsibilities", requiring them to ensure their children maintain regular school attendance and using health services appropriate for pregnant women and children under the age of five. Other components of the program focus on basic services linked to the co-responsibilities (education, health and legal identification of beneficiaries), providing direct support to beneficiary families through a package of social work-related services, and improving rural infrastructure (public works, housing, agricultural development).	Kitchens are built in select communities. These units are used to provide two snacks throughout the day (9am and 3pm). The morning snack consists of *Nutricereal* with a corn tortilla, and the afternoon snack is *Nutricereal*. The corn-based *Nutricereal* is high in calories and protein, and is fortified with vitamins and minerals. In addition to the nutrition component, the program also has an important health element: each child receives monitoring and evaluation of their development, including height, weight and hemoglobin, oral hygiene and receipt of de-worming medication.
Coverage/ access	In 2008 approximately 61% of children aged four and five attended preschool. In 2009 this figure dropped to 57%.	The program provides for the inclusion of poor families in urban and rural areas, with a particular focus on indigenous peoples. Figures from 2008 indicate that indigenous children under the age of five account for 4.5% of the total beneficiary population. The program provided coverage in 591 of the country's 621 jurisdictions in 2008. Some 70,600 households and 398,800 people benefit from the program.	In 2005 the program served 1,276 children aged 6-59 months in 31 community eateries. Each of these is located in the indigenous territory of Emberá.
Institutional arrangements	The MoE is responsible for preschool education. This includes supervision, guidance, training teachers and managing operating strategies for the other providers of preschool services.	*Red de Oportunidades* is comprised of various government institutions focused on providing its services to communities of extreme poverty in the country. The Ministry of Social Development is responsible for administering the program and receives contributions from the MoE, MoH, and Ministry of Finance. In 2007 the World Bank supported the "social protection in support of the *Red de Oportunidades* project".	The *Fundación Pro Niños de Darién,* which is authorized by the Government and Justice Minister of Finance, founded and operates the program. In addition, the program receives contributions from the Ministry of Social Development and MoH.
Financing/ cost-effectiveness	The MoE reports that spending on preschool education is US $17.66 per student. Private schools set their own rates.	When the program began in 2006, US $35 per month transfers were provided to recipients. In 2008 the figure was adjusted to US $50 per month. As of December 2008 the program had dispersed US $43,530,341, of which nearly US $27,000,000 were distributed that year. The 2007 agreement with the World Bank is for US $24,000,000.	The Ministry of Social Development provides an annual subsidy of US $100,000, and the foundation receives an undisclosed amount of private donations. A detailed description of the program costs per child is not available. In addition, the program receives assistance from the MoH, including supplements and de-worming medication.

ECD Intervention	National Preschool Program	Red de Oportunidades	Programa Preescolar de la Fundación Pro Niños de Darién
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Service providers	The public institutions include: kindergarten in public schools, which serve children aged four and five; and child guidance centers (COIF), which operate in state and municipal institutions and serve children aged two to five. The MoE also has three non-formal education programs: family and community centers for initial education (CEFACEI); early childhood education at home (EIH); and community centers for early education (CEIC). Private institutions include private kindergartens, which are taught in secular schools and religious and children centers; and the *Programa Madres Maestras* (Mothers Teachers Program), which is operated by the catholic church.	The distribution of funds is made through an agreement with the Post Office. This relationship is to be re-evaluated by the program. As part of the "co-responsibilities", the provision of education and health benefits is from teachers and health personnel.	Community mothers are the main source of service providers. In conjunction with the MoH and Ministry of Social Development, the program provides counseling to mothers in areas such as nutrition and instructions for administering products. Mothers are responsible for preparing the nutritional supplements in the community kitchen.
Quality assurance mechanisms	The MoE is responsible for quality assurance in preschool. In the past number of years three evaluations have taken place with support from the World Bank. In addition, UNICEF funded a study entitled "Qualitative study of views on the expected performance of students in Kindergarten and First Grade".	Evaluation of similar programs (*Oportunidades* in Mexico and *Red de Protección Social* in Nicaragua) has found that a CCT intervention can improve food consumption, improve diets and enhance recipients' wellbeing. As part of the World Bank project, a comprehensive monitoring and evaluation system is being designed and set up. The program has been recognized for its use of technology, and in particular its ability to ensure quality of service by scanning and digitalization of paper based forms in a central office.	As part of the monitoring aspect of the program, the weight and height of each child is recorded three times per year, and hemoglobin measured once a year. The program has a computerized registration system that records each nutrition assessment.
Challenges for going to scale and improving service delivery	Legislating compulsory education is an important first step to universal preschool education. Without the necessary financial support and implementation resources coverage remains very low. This is particularly true amongst poor and extremely poor children, where coverage is 18.1% and 9.2%, respectively. Geographical issues, which include major rivers and mountains areas, as well as scattered populations and a lack of infrastructure, make it difficult to reach certain facets of the population.	One of the most pressing issues the program is facing is the misuse of CCT funds. The project has expanded rapidly and as a result concern has arisen as to the efficacy of targeting and use of funds by beneficiaries.	A logical next step would be to strengthen the monitoring and evaluation component by developing a more rigorous impact assessment, as opposed to the current state where information is only recorded. The program is effective in reaching the target population, but this population is very small. In the future the program may consider expansion.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

(c) Classification of ECD Policies in Panama

Taking stock of ECD programs in Panama and categorizing them helps to understand the overall policy framework for ECD. As shown in the following table, an analysis of Panama's existing Enabling Environment, Degree of Implementation, and Policy Focus, leads us to classify the country as Emerging in terms of level of development of ECD policies.

Table 9. Classification of ECD Policies in Panama

ECD Policy Dimensions		Description
Enabling Environment	Emerging	The rights of children are protected in the Constitution and by the sanitary code – a legal instrument adopted in 1947 that entrenches the mother and child as vital components of society. In December 1990 Panama ratified the Convention on the Rights of the Child, ensuring that all children under 18 years are entitled to full physical, mental and social development and free speech. The MoH is the main body responsible for ECD in Panama. In recent years a number of legislative advancements have been made to construct a sturdy foundation for the future development of a comprehensive ECD policy. In October 2004 the National Nutrition Food Plan was established through Executive Decree No. 171 as a body capable of developing nutrition policy. In November 2005 the Government of Panama mandated universal and free medical care to all children under the age of five though all MoH establishments. Complementary health policies directed to impact ECD have been devised (such as rules related to food fortification to combat malnutrition). Law No. 4 of 2007 created a national neonatal screening program to reduce the rate of infant mortality. Law No. 28 of 2008 established and regulates Early Learning and Family Development, an intervention through the MoH that focuses on infant development. In 2007, the MoH launched the National Health Plan for Children and Adolescents. The aim is to ensure the rights of children and adolescents, to reduce gaps in health and integral development, and to support the proper development of the capacities of children and adolescents. One integral component of this includes strengthening community participation in managing health programs. In addition, the MoH has also designed the National Plan to Combat Infant Malnutrition 2008-2015. The plan focuses on the most vulnerable pregnant mothers, infants and children under 36 months of age in priority districts across the country to reduce the prevalence of severe malnutrition. Chapter V of the Constitution provides free and compulsory education for four and five year olds through public and private institutions. The MoE is responsible for overseeing the sector. In 2009, through the current government, Executive Order 201 created the Advisory Council on Early Childhood, and laid the groundwork for the construction of the Comprehensive Care Plan for Early Childhood. The council will aim to generate specific actions for ECD, including better coordination across public and private institutions to promote the maximum development of capacities of children. The Comprehensive Care Plan for Early Childhood will be submitted for its first review in October 2010. The Advisory Council on Early Childhood is also working to improve the structure, strengthen programs, and increase public-private partnerships aimed at ECD. A critical next step is to ensure that the Comprehensive Care Plan for Early Childhood and other work to improve ECD are not disjointed efforts, but rather work in close collaboration with other sectors and policy developments (most notably, the Comprehensive Health Plan for Early Childhood). All of these actions and achievements listed above amount to a substantial step in the right direction to improving the lives of children with investment in ECD. Panama is definitely making strides in the right direction and for this reason is listed as *Emerging* with optimism. It will be imperative to ensure access to the requisite financial resources and enforcement mechanisms moving forward.
Degree of Implementation	Latent	Since 2003 Panama has made substantial progress in reducing both child and infant mortality rates from 20.8 per 1000 and 15.2 per 1000 to 16.9 per 1000 and 12.8 per 1000, respectively. Another noteworthy improvement is the reduction in the prevalence of malnourished children under the age of five from 16.6% in 2003 to 12.4% in 2008. Coverage in education remains a large area of concern. Despite implementing mandatory preschool education, coverage remains very unequal, especially for poor and extremely poor children where coverage is 18.1% and 9.2%, respectively. The improvements noted above and elsewhere in this section are a direct result of the interventions, policies, and actions taken in the last number of years. To this point the efforts of the MoH cannot be underestimated. Despite these gains, chronic malnutrition and income inequality continues to impact development, and the legislated free healthcare has yet to achieve universal coverage. Bearing this in mind, the degree of implementation is classified as *Latent*. With continued efforts classification of *Emerging* should be attainable in the near future.

ECD Policy Dimensions		Description
Monitoring and Quality Assurance	Latent	The necessary inter-sectoral coordination and resources to develop and implement comprehensive ECD quality assurance mechanisms that encompass all services is yet to exist in the Panama arena. Some sectors have developed institutional bodies to evaluate, monitor and document information on ECD outcomes. For the most part these are independent and confined to a single service. Some of these have been developed with the financial and technical support of international bodies. For instance, the MoH has received assistance from UNICEF to undertake studies that monitor the state of iron deficiency and anemia for the *Programa de Alimentación Complementaria (PAC)* as well as support for an evaluation of the impact of the *Programa de Suplementación de Hierro*. A moderate stock of ECD information is available and will continue to be advanced with the establishment of the Advisory Council on Early Education.
Policy Focus	Emerging	As depicted in the previous section, several services exist in health, nutrition, education, and child protection, with some overlap and coordination across service area. In recent years these services have become better established. No comprehensive sector approach exists to achieve national ECD objectives.
Foco de la política	Emergente	Como se describe en la sección previa, existen diversos servicios de salud, nutrición, educación y protección infantil, con algún grado de superposición y coordinación a través de las áreas de servicios. En años recientes, estos servicios han logrado afianzarse. No existe un enfoque sectorial integral para el logro de objetivos de DIT a nivel nacional.

(d) Policy Options to Strengthen ECD Policies and Programs in Panama

Panama has quite a few programs to build from in order to strengthen ECD. However, it will be important for the country to develop a national policy for ECD and strengthen inter-sectoral coordination. The main challenge for Panama is developing a comprehensive approach to ECD that builds from the existing sectoral programs. In addition, reducing inequality in access to ECD services remains an important goal for Panama to reach the next stage of ECD development. Finally, ensuring that the quality of services is adequate is a key priority for this country.

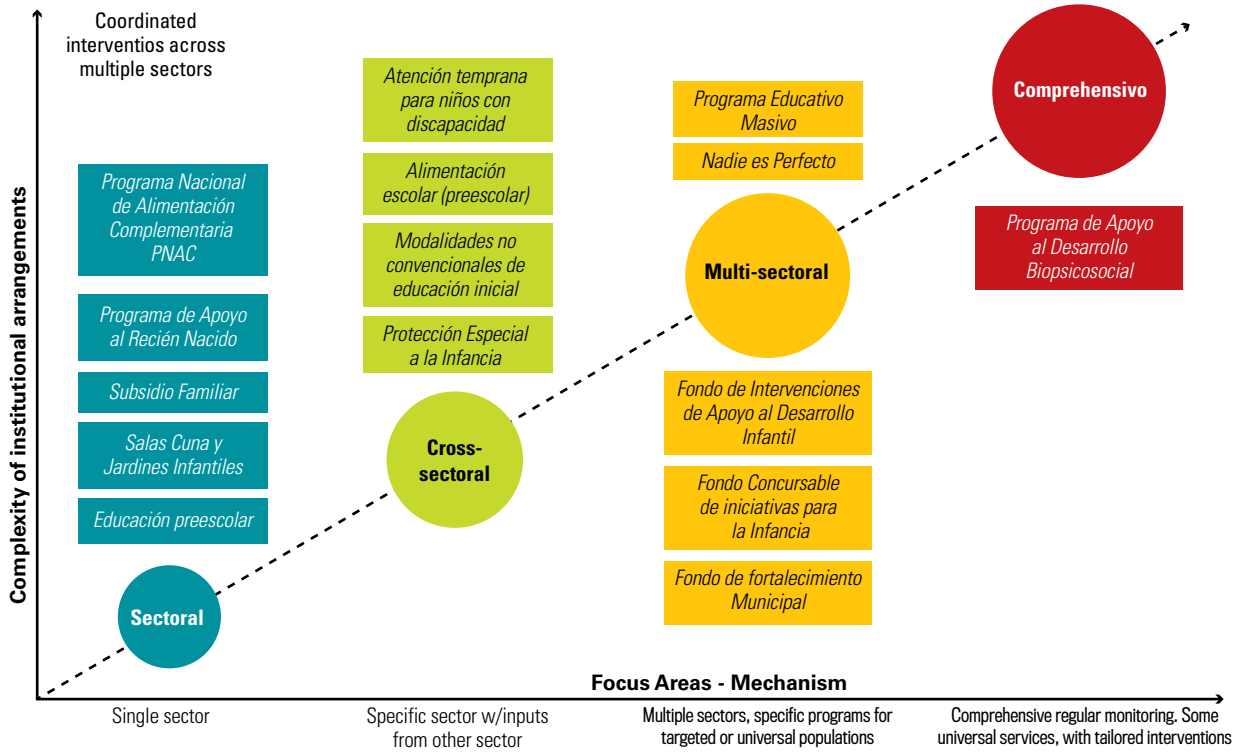
III. Chile

Chile is a country with about 17 million people, of which some 1.24 million are under five years old3. In recent decades, the country has implemented important policies, both in health and preschool education, and also in social protection to the poorest families, which have had a significant impact on the situation of children in early childhood. Despite significant progress in these areas, geographical and socioeconomic inequalities persist, highlighting the need to provide the highest priority to policies and programs aimed at early childhood. Infant mortality rates among children under one year old decreased to 8.3 per thousand births in 2007, rising to 10.8 however in some areas of the country. While poverty in 2009 affected 15.1% of the population, it affected 24.6% of children under four years old, showing that early childhood is the group with the highest incidence of poverty in the country, a figure that rises to 39.1% in rural indigenous areas. Moreover, the first population study on child development conducted in 2006 showed that about 30% of children under five years old have not reached all developmental milestones expected for their age group (35.9% in the poorest quintile versus 23.1% in the highest income quintile). Nursery care coverage for children under two advanced from 2.7% in 2000 to 7.8% in 2009. Similarly, the coverage of kindergarten for children two and three years old increased from 19.3% in 2000 to 30.6% in 2009. However, while 27.2% of children in the poorest quintile attend kindergarten, 50.8% of children in the richest quintile do. In 2008, 66.4% of children aged four and five attended preschool.

(a) ECD Programs in Chile

The policy aimed at early childhood – Chile Crece Contigo (Chile Grows with You) – is composed of a diverse set of programs. Some of them have been deployed for several years, and others were created in the framework of Chile Crece Contigo in 2007. According to the typology described in Section 3, among these programs are sectoral, cross-sectoral, multi-sectoral and comprehensive interventions. Figure 4 presents an inventory of ECD programs in Chile by type of intervention.

Figure 4. Inventory of ECD programs in Chile, by type



Source: Authors.

3 While the definition of ECD used in this document applies to children aged 0 to 6, in Chile, census data are available in a quinquennial format; in this case 0 - 4 years old.

Table 10. Categorization of Selected ECD Programs in Chile

ECD Intervention	Programa Nacional de Alimentación Complementaria (PNAC)	Programa de Apoyo al Recién Nacido (PARN)	Subsidio Familiar (SUF)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Primary policy objective	The goal of *Programa Nacional de Alimentación Complementaria* (National Complementary Food Program) is to contribute to growth and development, fostering the maximum genetic potential of children throughout the country. It intends to support the nutritional status of pregnant women, as well as to ensure harmonious fetal development, successful breastfeeding, and normal growth development. In addition, it expects to contribute to the reduction of prevalence of chronic diseases in adulthood.	The *Programa de Apoyo al Recién Nacido* (Newborn Support Program) aims at providing support to families in order to ensure that all children have access to the best care conditions during the first stage of their development.	The primary objective of *Subsidio Familiar* (Family Subsidy) is to support the needs of the most marginalized children through a monthly cash transfer.
Brief description	The program was created in 1952 when regular monitoring of prenatal health for pregnant women and health checks for children less than six years of age were instituted. The program consists of the delivery of milk and food supplements that are appropriate to the nutritional needs of different populations, which are provided during health checks.	The program began implementation in 2009 as one of the new features of *Chile Crece Contigo* (CHCC), and was carried out in all maternity wards of the public health system, serving about 70% of the annual births in the country. It consists of the delivery of a set of basic articles for newborns, and guidance for families. The set includes items to encourage the attachment bond, and articles for the newborns' basic care (hygiene), an equipped crib, and clothes for the first months of the newborn's life. Parental guidance is carried out at the ward, where educational materials are also distributed.	The program was created in 1982 and is aimed at families living in extreme poverty, whose children do not have access to social security. Currently, beneficiaries are pregnant women, newborns and children under 18 whose families are part of the 40% most vulnerable households in the country.
Focus areas/ intervention mechanisms	The program delivers different nutritional products specifically designed for the different population groups: milk with Omega 3 (for pregnant and lactating women); iron, zinc, copper and Vitamin C fortified milk (for children under six years of age); fortified, low fat and calorie cereal milk with added calcium (for overweight children under six), and cream soup with micro and macro nutrients (to diversify the children's diet). Since 2000, the program added special food for premature babies, and children with PKU or special metabolic diseases.	The sets are distributed at the maternity wards. Delivery is in charge of the professionals attending birth and postpartum. It's a social and educational benefit, with universal coverage for the population served by the public health care system, regardless of socioeconomic status. The set is provided when the mother and newborn leave the hospital.	*SUF* is a welfare benefit that focuses on the most vulnerable families. It provides a US $ 13 transfer per month. Recipients must apply through the municipalities, and their socioeconomic vulnerability is established through the *Ficha de Protección Social* (Social Protection Form), the national instrument for assigning the major social benefits.
Coverage/access	This program has universal coverage, and in 2009 provided coverage to 83.2% of the pregnant women and children who are under regular supervision of health. The public health care system provides services to approximately one million beneficiaries per month.	Coverage is 100% of births attended in public health care facilities. In 2009, it served approximately 160,000 newborns.	The transfer is aimed at families with children with no access to social security, which form part of the 40% most vulnerable households in the country. Since 2007, the program's coverage has changed, fixing 100% coverage of applicants meeting requirements. As of August 2010, the program shows a monthly average coverage of 2,060,039 beneficiaries (including pregnant women, newborns, mothers, and children less than 18 years of age).

ECD Intervention	Programa Nacional de Alimentación Complementaria (PNAC)	Programa de Apoyo al Recién Nacido (PARN)	Subsidio Familiar (SUF)
Institutional arrangements	The program is operated by the MoH through the nationwide public health care system. Nutritional products are distributed through the primary health care system, which in most parts of the country is run by the municipalities and other decentralized health services.	The program is operated by the MoH, and funded by the Ministry of Planning, as part of CHCC. The purchase of set items is done by bidding through the CENABAST (National Health Care System Supply Central Office) which distributes sets to the 180 public maternity wards throughout the country.	The transfer is allocated by the municipalities on the basis of compliance with requirements which are verified by the *Superintendencia de Seguridad Social* (Social Security Superintendent's Office), and monitored by the Ministry of Planning. Subsidies are paid through the *Instituto de Seguridad Social* (Social Security Institute) and its payment facilities throughout the country (including private banks).
Financing/cost-effectiveness	The program is completely funded by the Government, and is free for users, regardless of their socioeconomic status. In 2009, the program's budget was US $70.4 million.	The program is 100% funded by the Government and is free for users, regardless of their socioeconomic status. Its annual budget is US $ 25 million.	The program is 100% Government funded. Its annual budget is US $ 329 million.
Service providers	Nutritional supplements are purchased from the private sector through competitive bidding, and distributed through the public health care system.	Sets of items are purchased from the private sector through competitive bidding, and are distributed through facilities of the public health care system.	Municipalities run the application process and the allocation of benefits. The Social Security Institute's payment facilities deliver cash transfers to beneficiaries.
Quality assurance mechanisms	The MoH is responsible for quality control of the dietary supplements. It monitors, oversees and controls all processes involved in production, distribution, and delivery to beneficiaries, and evaluates acceptance and health effects on the different groups.	The program established quality standards to set suppliers. CENABAST and the MoH conduct the quality control procedures, from receipt of the products to their delivery to recipients, through all stages of the supply chain.	The Ministry of Planning monitors the application process and allocation of benefits monthly, through the municipalities. The Social Security Superintendent's Office oversees allocation and continuance of subsidies.
Challenges for going to scale and improving service delivery	The main challenge this well established program faces is to continue researching in order to adjust products to the emerging nutritional needs of its beneficiaries.	The greatest challenge is to strengthen the program and the assigned budget. Developing stable evaluation mechanisms to assess the program's results and impact in terms of children's attention, care and development is imperative.	This benefit is a well established service of the Chilean Social Protection Network, and has expanded its coverage. One challenge is to ensure stable mechanisms to assess the program's impact on the lives of children and their families.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

Table 10 above shows some details of the most important interventions in Chile aimed at early childhood. It is important to point out that all of these interventions are organized in an integrated policy called Chile Crece Contigo, whose axis is the Biopsychosocial Development Support Program that tracks the trajectory of development of each child from the first prenatal check to the entry of them into the school system around five years of age.

Table 11. Categorization of Selected ECD Programs in Chile

ECD Intervention	Salas Cuna y Jardines Infantiles	Atención Temprana para Niños con Discapacidad	Programa Educativo Masivo
Classification	**Sectoral**	**Inter-Sectoral**	**Multi-Sectoral**
Primary policy objective	The aim of *Salas Cuna y Jardines Infantiles* (Nurseries and Kindergartens) is to promote equitable access to child care and early education in its various forms, depending on the children's stage of development.	*Atención Temprana para Niños con Discapacidad* (Early Care for Children with Disabilities) seeks to support the needs of young children with disabilities or special needs.	The goal of *Programa Educativo Masivo* (Massive Educational Program) is to help create a social environment that fosters early childhood development, by raising awareness, promoting and educating on proper care, timely stimulation and the developmental needs of children during early childhood. It is thus aimed at adults who are around children, especially their parents and caregivers.
Brief description	The JUNJI (Kindergarten National Board) and the Integra Foundation provide quality early childhood education to poor or socioeconomically vulnerable children under four years of age through the creation, promotion, supervision, and certification of nurseries and kindergartens managed directly or by other institutions. The institutions have different modalities, including non-conventional.	The program involves the delivery of technical support for children with special needs, both for themselves and their environment. This program was created as part of CHCC, to specifically support the special needs of young children with disabilities.	The program operates through different means and guidance and educational tools. The website *www.crececontigo.cl* provides information on child development, counseling by specialists, downloadable materials, and online interactive forums, among other services. *Fono Infancia* (Childhood Line) is a telephone counseling service run by ECD specialists. The program also broadcasts a weekly national radio show devoted to ECD related issues. Educational TV shows, called *Crece Contigo TV*, are played at all health centers. Additionally, the program has produced educational materials for adults (booklets), which are distributed nationally.
Focus areas/ intervention mechanisms	The program offers child care and early education, as well as nutrition and training in parental skills and child development . There are different educational levels according to the children's ages. Arrangements vary according to the needs of families (extended hours, or intercultural education, for example) and to difficulties in access to facilities (seasonal kindergartens, early education in prison facilities, and radio shows, among others).	The *Fondo Nacional de la Discapacidad* (National Fund for Disability) delivers technical aids (tools, prosthetics, orthotics, etc.) that allow children with special needs to realize their full potential for development since birth. Children are referred from specialized health care.	Through various means, the program addresses all relevant issues to help parents and caregivers acquire adequate information, providing the necessary support mechanisms to meet their questions. The topics are broad and are prepared by specialists in the field. Materials are available in formats appropriate to the needs of the recipients.
Coverage/ access	Child care and early education services are aimed at children less than four years whose families are part of the 60% most vulnerable households in the country. In the case of nurseries (for children under two), priority is given to children whose mothers or primary caregivers work outside the home, seek employment or study. Kindergarten or equivalent services (for two and three year olds) are aimed at all children. In 2010, coverage is: 85,000 children under two years attend nurseries, and 127,472 children attend kindergartens..	These services are aimed at children with special needs who come from families of the 60% most vulnerable households in the country. The services are protected by 2009 legislation, thus ensuring coverage of all children meeting requirements.	The program has universal coverage and serves the entire population, mainly adults who have a direct relation with children. The website is visited by approximately 125,000 different users every month (it is the service website with the highest coverage in the country). *Fono Infancia* receives around 4,000 calls per month. The radio show is broadcast by the network with the highest coverage in Chile.

ECD Intervention	Salas Cuna y Jardines Infantiles	Atención Temprana para Niños con Discapacidad	Programa Educativo Masivo
Institutional arrangements	The JUNJI and Integra Foundation have a wide network of nurseries and kindergartens throughout the country, some directly managed by them, other managed externally (mainly, municipalities. In the case of external management, both institutions transfer resources through subsidies per child served, the value of which varies depending on the service delivered.	The application process is run through municipalities and/or public health care services by referral. Socioeconomic vulnerability is evaluated through the Social Protection Form. The benefits are allocated by the FONADIS (National Disability Fund).	The Ministry of Planning, through the Executive Secretariat of Social Protection, is responsible for national coordination of CHCC and runs this program in close cooperation with the Ministries of Health, Education and Culture, and with municipalities that distribute the educational material through the CHCC community networks.
Financing/ cost-effectiveness	Early education services are 100% funded by the Government and are free for all qualifying families. The 2010 annual budget was US $ 542 million.	The program is 100% funded by the Government. The 2010 annual budget was US $ 900.000.	The program is 100% funded by the Government. The annual budget for 2009 amounted to about US $ 750,000.
Service providers	Child care and early education services are provided directly by JUNJI and Integra Foundation, or through municipalities that receive a monthly subsidy per child served. The food is provided by JUNAEB (National Board of Student Aid and Scholarships), which is responsible for all school feeding programs across the country.	Technical aids are delivered by FONADIS, and acquired through competitive bidding from private providers, both domestic and international.	The different educational tools are directly managed by the national coordination of CHCC or through other institutions (*Fono Infancia*, for instance, is run by the Integra Foundation, and the radio show is bid annually to private radio networks).
Quality assurance mechanisms	Both institutions, together with the Preschool Department at the MoE, have established a set of quality standards for each of the services provided. Quality assurance mechanisms are designed, but are at an early stage. Legislation to create an Education Superintendent's Office Is under consideration. This entity could regulate and monitor the quality of ECD educational services.	FONADIS sets quality standards for the technical aids to be purchased, and evaluates standards' compliance at the time of receipt.	The educational contents are prepared by national experts and are distributed after being tested on potential users. The same quality control mechanism applies to audiovisual contents.
Challenges for going to scale and improving service delivery	The CHCC Act that ensures access to child care and early education services requires institutions to serve vulnerable populations, and demands expanding non-conventional modalities to serve the families in need of such services. A major challenge is the institutionalization and consolidation of quality assurance mechanisms for early childhood services.	Knowledge of the specific needs of potential beneficiaries should be more accurate. This could be achieved by increasing coordination with health care services. Administrative arrangements should be made to ensure flexibility in the processes, focusing on supporting emerging needs.	A program as the one described requires constant content update, use of new technologies, and evaluation mechanisms to assess impact on recipients. The implementation of such mechanisms is one of the major challenges this program faces, along with future consolidation and securing the necessary resources.

Table 12. Categorization of Selected ECD Programs in Chile

ECD Intervention	Fondo de Intervenciones de Apoyo al Desarrollo Infantil	Programa de Apoyo al Desarrollo Biopsicosocial (PADB)
Classification	**Multi-sectoral**	**Comprehensive**
Primary policy objective	The objective of the *Fondo de Intervenciones de Apoyo al Desarrollo Infantil* (Child Development Interventions Support Fund) is to provide funding at the local level –specifically, the CHCC Community Networks run by municipalities –for the creation and continuance of ECD interventions.	*Programa de Apoyo al Desarrollo Biopsicosocial* (Biopsychosocial Development Support Program) seeks to strengthen and promote the comprehensive development of children from birth to age four, through a series of quality psychosocial interventions designed to complement prenatal care, childbirth support, child screenings and care for hospitalized young patients.
Brief description	Every year, the CHCC Community Networks can submit projects devised to develop one or more of the following kinds of interventions: stimulation rooms at health care centers or community centers, toy libraries, mobile stimulation services, stimulation services at the home, or improvement and/or extension of pre-existing stimulation services. These projects are aimed at children who are at risk of showing, or already showing developmental delays. The submitted projects must be designed in accordance with a pre-assigned budget.	This program tracks the developmental trajectory of each child from the first prenatal screening until he or she is four years old, thus strengthening the regular health checks which have been established in the country for decades. The program is organized into 5 areas, according to the children's developmental stage: strengthening of prenatal development, personal attention of the birth process, attention to the development of hospitalized children, strengthening of the children's comprehensive development, and special attention to children at risk and/or vulnerable.
Focus areas/ intervention mechanisms	The projects deal with different needs of children at risk of showing or already showing developmental delays. Children needing support are identified through developmental tests applied during regular universal health checks. They are referred by the public health care system to the different ECD services available in the area. The CHCC Community Networks run by the municipalities oversee referral follow-up and effective care of children.	Through this program, children enter CHCC automatically during the first prenatal health check. From then on, a sequence of actions takes place and continues until children are 4 years old, when they enter preschool. A range of services that complement regular health checks are deployed, also considering possible critical situations that may occur during the course of a child's development, such as hospitalization, vulnerability or risk, or developmental delay or deficit. Since the approach is psychological, the health care system refers children and their families to other educational or social services available in the area. The process is backed by the CHCC Community Network, and run by the local Municipality.
Coverage/access	The Fund has national coverage and functions at the 345 municipalities in the country. Between 2007 and 2009, about 1,000 services of different types were created, thus serving approximately 150,000 children throughout the country.	Coverage is nationwide and the program serves 100% of children in the public health care system. This represents about 75% of Chilean children, regardless of socioeconomic status. About 1 million children are covered by this program.
Institutional arrangements	The Ministry of Planning coordinates the Fund through the Executive Secretariat of Social Protection System, the body tasked with operating CHCC at the national level. The allocated resources are transferred to the municipalities that develop projects, and which are supervised by the CHCC regional intersectoral coordination agencies.	The public health care system is in charge of the program, especially at the primary care level. Public maternity wards and pediatric hospitals also participate actively. The CHCC Community Network, coordinated by the Municipality, is responsible of responding and providing attention to the referrals made by the health care system in the most diverse areas that affect or may affect the development of children served by CHCC.
Financing/cost-effectiveness	The Fund's annual investment is US$ 2.5 million. It is funded by fiscal resources, which are nearly doubled with local contributions by municipalities.	The program is 100% funded by fiscal resources. Its budget is assigned exclusively to the services that complement those provided during regular prenatal and child health checks. The 2010 budget amounts to US $ 32 million.
Service providers	Municipalities and local education and health organizations generally run the projects, in alliance with other public or private institutions that form part of the CHCC Community Network.	Services are provided by the public health care system (primary care, maternity and pediatric hospitals), with the intervention of the CHCC Community Network in areas of care, early education and social protection, mainly.

ECD Intervention	Fondo de Intervenciones de Apoyo al Desarrollo Infantil	Programa de Apoyo al Desarrollo Biopsicosocial (PADB)
Quality assurance mechanisms	Tecnical guidance and quality standards are provided for each of the projects funded. The program also has control mechanisms and tools, especially in the case of services provided to children.	Every year, the program provides a protocol for the interventions considered, including quality standards for services. The MoH is in charge of supervision, both at the national and regional levels. The transferred resources are conditioned on compliance with basic standards.
Challenges for going to scale and improving service delivery	The challenges this program faces are related to the expansion of projects in order to serve all areas, and to ensuring services and securing funding of existing and established interventions. It must also carry out a systematic assessment of results and impact of services on children's development.	The program is established as the axis of CHCC and has national coverage. Its main challenges are those related to periodic evaluation and update of yearly benefits and services, as well as assessments of the interventions' results and impact.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

(e) Classification of ECD Policies in Chile

Given that Chile has a specific public policy for early childhood development –Chile Crece Contigo–, it is the policy, rather than the country, that must be classified. According to the framework presented in Section 4, the Enabling Environment and Degree of implementation are in the Established level of development. The Policy Focus is in the Mature stage, while the Monitoring and Quality Assurance dimension is classified as Emerging. In terms of improving the policy, this last dimension offers the greatest challenge.

(f) Policy options to Strengthen ECD Policies and Programs in Chile

The creation, in 2006, of Chile Crece Contigo as a comprehensive early childhood development policy has been a significant step towards investing decisively and with quality in the early years , in order to ensure equal opportunities from birth and addressing persistent inequalities in the country. The law that created CHCC, which was passed in 2009, helps to bring stability and to secure funding for the policy's implementation over time.

However, though having taken major steps, Chile seems to face chief challenges in this area, one of the most significant being to ensure the quality of benefits, services and programs that are accessible to young children and their families. Not only is it important to set standards for each of the services provided, but also to generate support mechanisms for their compliance and to develop effective tools for quality control.

Another relevant challenge is to strengthen the CHCC inter-sectoral coordination bodies, to make sure that the follow-up and monitoring processes of the developmental trajectory of children are adequate and provided in a timely manner to support the needs of each child during his or her early life.

Table 13. Classification of ECD Policies in Chile

ECD Policy Dimensions		Description
Enabling Environment	Established	The legal framework for protection and special attention to children, in a rights-oriented child development approach, has been developed in Chile during the last two decades, especially after the country ratified the Convention on the Rights of the Child in 1990. The legislation has been adapted to the emerging problems of children in the country and to support families' needs, particularly those in the most vulnerable situation. The law that established Chile Crece Contigo, passed in 2009, recognizes the importance of early childhood development as a priority public investment policy; establishes legal guarantees for a package of benefits, services and programs; and regulates bodies for articulation and intersectoral coordination, essential to the operation of a comprehensive policy that tracks individual development of each child covered by CHCC. The enactment of the recent legislation involves relevant challenges for the public institutions responsible for its implementation. Chile has the means and most of the resources needed to strengthen the policy. The effectiveness of such means is still to be evaluated.
Degree of Implementation	Established	The policy includes a variety of programs, coordinated by means of a personalized follow-up mechanism of children's development. Most programs have universal coverage, regardless of socioeconomic status, and those programs focused on a determined segment of the population have universal coverage which is protected by law. The programs focus specifically on early childhood development. The greatest challenges the program faces are implementing of new programs, created specifically in the context of CHCC, and ensuring universal coverage and quality for pre-existing programs.
Monitoring and Quality Assurance	Emerging	While some programs have standards and quality assurance mechanisms, especially those in the area of health care, most programs require substantial progress regarding this issue. Early education and preschool are the areas facing the major challenge.. While progress has been made in the establishment of quality standards, there are no mechanisms for ensuring them, and no specific institutions have been created.
Policy Focus	Mature	The main strength of early childhood policy in Chile is precisely the holistic approach that guides the efforts of CHCC. The policy is specifically directed at young children, rather than children in general. The need to offer comprehensive services has led to very significant challenges for institutions providing them. However, a new, more comprehensive intervention approach, has gradually been established, offering advantages to all participating sectors.

6. Conclusions

Countries in Latin America and the Caribbean face many development challenges, but perhaps the most critical is that of human development. The foundations for human development are laid in the early years. When young children receive adequate nutrition, stimulation, and healthcare, they grow strong, able to learn and become productive citizens. When young children do not have healthy early childhood experiences, the impact on life outcomes is severely detrimental.

As countries in the region strive to ensure that all children can reach their full potential, they can learn from each other as well as from countries outside the region in terms of how to design and implement effective ECD policies. In this Policy Note, we have developed a framework to categorize programs and to classify policies to benchmark ECD systems in order to help policy makers identify the current stage of development of their ECD system and, importantly, strategies to develop further. There is not one identical path for all countries to reach the ECD goals, but there can be a set of directions, or "Roadmap" to help countries identify their own unique path. This Policy Note has identified such a "Roadmap" along four critical dimensions – Enabling Environment, Degree of Implementation, Monitoring and Quality Assurance, and Policy Focus.

In order for countries to strengthen their ECD systems, a first step is for each country to take stock of all its interventions in this area, understanding how they have evolved along a group of key characteristics described in Section 3 that include: (i) Focus area; (ii) Coverage/access; (iii) Institutional arrangements; (iv) Financing; (v) Service providers; (vi) Quality assurance mechanisms; (vii) Challenges for going to scale and improving service delivery. Building on this inventory of ECD programs, countries can use the ECD Policy Classification Framework introduced in Section 4 to identify their level of development (Latent, Emerging, Established, Mature) along the four dimensions (Enabling Environment, Degree of Implementation, Monitoring and Quality Assurance, and Policy Focus). A final step is to identify policy options to strengthen ECD policies and programs to achieve the goal of ensuring that all children can reach their full potential.

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7. Annex: Classification of Selected Regional Programs by Category

A1:Table 14. Selected Sectoral Programs in Latin America and the Caribbean

ECD Intervention	Support for Seamless Education Program (Trinidad and Tobago)	Vaso de Leche (Peru)	Programa de Abasto Social de Leche (Mexico)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Primary policy objective	The first phase of *Support for Seamless Education Program* endeavors to improve the equity, quality and relevance of educational services provided in ECCE and primary education levels; and to improve sector management including monitoring and evaluation.	The *Vaso de Leche* (*VL*) feeding program in Peru aims to reduce child malnutrition by providing milk and other nutritional commodities to children six years old or younger and pregnant and lactating mothers in poor areas.	The *Programa de Abasto Social de Leche* (*PASL*) provides high-quality milk to improve the nutrition of low-income families, pregnant and lactating women, older adults, and in particular, young children.
Brief description	The Government of Trinidad and Tobago developed a strategic plan, Vision 2020, which states that economic diversification and the creation of a highly skilled labor force are the keys for ensuring future competitiveness. To help achieve this goal, the MoE devised a multi-phased initiative called *Support for a Seamless Education System Program*. The program is part of an overarching attempt to harmonize the efforts of the MoE in addressing equity, quality, efficiency, and increased participation of children in ECCE through secondary education.	The *VL* program was initiated by the World Bank in 1984. The program began in Lima and has since expanded throughout the country. The program became increasingly popular during the economic stress and downturns of the 1990s. Recently, concern over the stability of the program has sparked public protest.	*PASL* was implemented in 1944 with the inauguration of the first public milk-producing company (now called *Liconsa*). In 1994 the program was revised to become part of the Ministry of Social Development (MoSD). Nowadays, *Liconsa* is a state-owned entity devoted to the industrialization of high-quality milk and its distribution at subsidized prices, in order to contribute to the proper nutrition of millions of disadvantaged Mexicans. *Liconsa's* milk is fortified with the following nutritional elements: iron, zinc, folic acid and vitamins A, C, D, B_2 and B_{12}.
Focus areas/ intervention mechanisms	The first phase of *Support for a Seamless Education System Program* has four components, with the first being the most substantive. This component aims to increase equity and quality of educational services to all early education aged children. This includes the construction, upgrading and equipping of 50 ECCE centers (for three to four year olds) and the implementation of an extensive training program for all staff. The component also supports students with disabilities with the establishment of 12 demonstration schools (six ECCE and six primary schools) to model inclusive education practices.	Despite its name, the *VL* program is not confined to the distribution of milk or milk substitutes. In some instances, cereals or a combination of commodities are distributed in lieu of, or in addition to, milk products.	In addition to boys below the age of 12 and girls younger than 15, pregnant and lactating women, chronically ill and disabled people, women 45 to 59, and adults older than 60 are served by *PASL*. The sale of milk at preferential rates is available to people living in poverty. The authorized weekly allotment of milk per person in a household is four liters. If a household has six or more beneficiaries the weekly allotment is capped at 24 liters.
Coverage/access	Approximately 87% of three to four years olds are enrolled in ECCE programs. However, recent assessments indicate that 65% of centers are in poor or critical condition and pose risks to the safety of children and staff. Less than 5% meet recent standards pertaining to space, layout, and teacher training. Investment in the 50 centers prioritizes communities that rank lowest with the Basic Needs Index.	Priority is given to households with children aged six and under, as well as pregnant or lactating women. After that, on a priority basis, the program caters to children aged 7 to 13 and people with tuberculosis. In total, the program reaches 4.2 million beneficiaries, of which 2.8 million are children under the age of six. Reports indicate that at times the age limit for children is arbitrarily extended beyond the age of six. Furthermore, studies indicate that the *VL* program does not effectively target pro-poor. In 2003, 75% of beneficiaries lived in urban areas, and the remaining 25% in rural areas.	In 2008 more than 6,000,000 people benefited from *PASL*. This includes 3,807,042 girls and boys under the age of 12, and 56,869 pregnant or lactating women. Beneficiaries of the program are selected according to socioeconomic and demographic studies that focus on geographic zones with a high prevalence of malnutrition. Operations cover 1,864 of 2,445 municipalities in Mexico.

ECD Intervention	Support for Seamless Education Program (Trinidad and Tobago)	Vaso de Leche (Peru)	Programa de Abasto Social de Leche (Mexico)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Institutional arrangements	The MoE is the largest ministry with about 17,000 staff, including 14,000 teachers. Operational responsibilities are being de-concentrated to eight regional offices. A major area of emphasis for the MoE is the management of teachers and their professional development. All new teachers entering the system are required to have, at a minimum, a B.Ed, which only 30% of current teachers have.	The Ministry of Economy and Finance is in charge of *Vaso de Leche*. All other food-based programs are the responsibility of the Ministry of Women and Social Development. It has been suggested that the *VL* program may be best served as part of this ministry.	The MoSD is responsible for *PASL* through SEDESOL. In response to studies conducted in the 1990s that indicated large segments of beneficiaries remained malnourished, the MoH teamed with the MoSD to enhance the nutritional content of the milk. Early results indicated a decrease in the prevalence of anemia and iron deficiency among children aged 12 to 24 months, from 27% to 17%, and 20% to 4%, respectively.
Financing/cost-effectiveness	The first phase of *Support for Seamless Education Program* requires US $62,500,000. Of this, the IDB is financing US $48,750,000 and the Government the remaining US $13,750,000. The first component, early child development, accounts for US $44,845,728, or 71.7% of the investment.	Funding for the *VL* program is provided by the National Treasury and is directly transferred from the central government to municipalities. The municipalities are responsible for buying and transferring food to the registered local mothers' committee. The budget is reported to be US $136 million.	The price per liter of milk is $4.00 pesos and is established by *Liconsa*. Compared with the average market price of commercially pasteurized milk, this represents savings of approximately 60% per liter. *Liconsa* reports that $2,027,096,000 pesos were allocated for subsidies and transfers in 2007.
Service providers	The MoE is responsible for service provision of ECCE. Included with these responsibilities is establishing criteria for admission of children to the centers (outlined in the implementation manual) and the hiring and training of teachers. Demonstration schools are equipped with special education teachers.	Each municipality has an administrative committee and a *VL* Mothers' Committee elected from within the respective neighborhood. These organizations are responsible for determining program beneficiaries, registering beneficiaries, and the administration and allocation of goods within the municipality.	*Liconsa* distributes 90,526,857 liters of milk each month, of which 75% is liquid form and 25% is powdered milk. The powdered milk is most effective for reaching remote communities. The milk is distributed through a network of 9,691 *Lecherías* (dairy centers) located throughout the country.
Quality assurance mechanisms	The MoE will receive technical assistance to develop a comprehensive evaluation and monitoring framework to inform subsequent phases of the program. Among the innovative features in this operation are: i) the evaluation of various ECCE models with respect to their cost effectiveness and quality of care; and ii) an external evaluation of the demonstration schools. In addition, mid-term and final evaluations of the project will be conducted along with an annual audit. The educational planning division will monitor the program implementation.	The National Food Center is responsible for determining the nutritional value for each food portion. The Mothers' Committee and municipalities receive continual monitoring on the implementation, financial management, and delivery of the program. The Government of Peru conducts surveys to the well-being of citizens, which are used to assess the efficacy of the program. In addition, research institutes and universities have undertaken a number of external evaluations.	In order to ensure high quality milk, *Liconsa* applies strict quality control measures (ie: more than 13,000 control tests) to the acquisition of raw materials, the production process, and to product distribution. A combination of internal and external evaluations track beneficiary targeting; assess health benefits; and measure compliance with the projects' goals and objectives. The National Institute of Public Health conducts several studies that track and evaluate the health benefits to children.

ECD Intervention	Support for Seamless Education Program (Trinidad and Tobago)	Vaso de Leche (Peru)	Programa de Abasto Social de Leche (Mexico)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Challenges for going to scale and improving service delivery	Efforts to modernize the education sector continue to be hampered by the relatively slow speed and bureaucratic nature of the MoE.	-The program should concentrate on effective targeting and service delivery to malnourished children from birth to the age of six. - Several concerns have arisen as to the best method to provide for malnourished children. Entitled the RECURSO program, the Government of Peru has teamed with the International Bank for Reconstruction and Development to conduct in-depth analysis of social programming in Peru.	The program needs to continue to improve targeting mechanisms to reach the most malnourished children and beneficiaries. Furthermore, continued education programs are required to both ensure that the milk is being allocated to children and not consumed by others in the household, and to detail the health benefits of regular, consistent intake (approximately two glasses per day) of milk.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

A2: Table 15. Selected Sectoral Programs in Latin America and the Caribbean

ECD Intervention	Educación Inicial (Mexico)	National Preschool Program (Argentina)	National Preschool Program (Uruguay)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Primary policy objective	*Educación Inicial* offers compensatory education with priority given to rural zones, indigenous people, and groups who are marginalized to improve child development and school readiness for children from birth to four years of age and their parents.	Argentina's National Preschool Program aims to provide quality education and equal opportunities to all children for the development of their cognitive, emotional, social and motor skills, with a particular emphasis on improving school readiness.	Uruguay's National Preschool Program aims to promote the integrated development of each child within their bio-psychosocial environment, providing the stimuli that they need to attain their fullest possible development.
Brief description	*Educación Inicial* was founded in 1993 and is placed within the National Council for Educational Development (CONAFE). The program is one of the largest in the area and targets pregnant women and children from birth to age four living in rural, peri-urban and urban areas with high levels of marginalization and indigenous populations. Upon completion of *Educación Inicial*, children are expected (and adequately prepared) to enroll in the national kindergarten program.	Responsibility for preschool (and primary) education was decentralized to the provincial level in 1978. Both free public schools and private institutions that charge fees to students supply education. In 2007 the Ministry of Education, Science and Technology received financial and technical assistance from the IDB. One component of the investment is in new works and the expansion of educational infrastructure at the preschool level.	Both free public schools and private institutions that charge fees to students supply education. In the early 1990's a major constraint to preschool education was the lack of teaching infrastructure. In response, during the 1995 – 2004 period a priority of education policies in Uruguay was to expand preschool coverage, with particular targeting of lower-income families. By 2002 nearly 800 new classrooms were made available and were accompanied by an increase in the number of preschool teachers.
Focus areas/ intervention mechanisms	The program uses a combined strategy of parent education and child services. The services delivered include prenatal education; education to be a mother; child assessments; early stimulation; parent education and support; and community participation. To cater to indigenous groups, services are provided in the native language and educational materials are culturally tailored. Over an eight-month period, home visits of one hour are conducted twice a week, individual consultations of one hour are held once a week, and parent meetings lasting two hours are held once a week.	In general, public schools operate in two shifts (morning and afternoon) from the beginning of March to the end of November, and run for three and a half hours, five days a week. Operations vary amongst private schools. Preschool education is separated into three levels: level one (age three), level two (age four) and level three (age five).	Public preschools operate five days a week during a 180 day school term. Most of the institutions operate in two daily shifts (morning and afternoon). Private schools determine their own operational schedule.
Coverage/access	In May 2007, the program reached 2,085 municipalities and 22,855 communities, serving 367,986 parents and 409,871 children. Some 70% of program participants reside in rural areas, and 21% are indigenous. The program targets the most underprivileged participants, with 19% and 47% being reported as very highly marginalized and highly marginalized, respectively.	Approximately 95% (648,828) of all five year olds attend preschool. Of which, 79% (or 513,099) attended public schools in 2008. At the four and three year old levels, 481,929 and 234,644 attended preschool, with 67% and 57% attending public schools, respectively. In general, private schools have higher attendance rates in urban areas.	Preschool is for children aged three to five. Since 1999, the gross enrolment of preschool students has improved from 60% to 81% in 2007. Specifically, the enrolment of children aged four and five, whom are legally required to attend preschool, has steadily improved and attendance is near universal today. Private schools are more prominent in Montevideo.
Institutional arrangements	The Unit for Compensatory Programs of CONAFE manages the program and channels it through State Coordinating Units for *Educación Inicial* to communities in all states. The National Constitution, a series of plans, laws, decrees and regulations provide a strong legal basis for the program.	The 1993 Federal Law of Education confined preschool policy to the provision of education services for children aged three to five, and universal provision to five year olds. The 2006 National Law of Education extended universal provision to four year olds. The Ministry of Education, Science and Technology is responsible for national policy at the federal level, and the various provincial ministries of education are tasked with administering and executing education.	Since the passing of the 1985 Education Law, the education system has been the responsibility of the National Administration for Public Education (ANEP), the Ministry of Education and Culture, and the University of the Republic. ANEP is in charge of preschool, primary, and secondary education; pre-service, and in-service teacher training. In total, the ANEP administers and oversees the education for about 720,000 children and some 45,000 employees.

ECD Intervention	Educación Inicial (Mexico)	National Preschool Program (Argentina)	National Preschool Program (Uruguay)
Classification	**Sectoral**	**Sectoral**	**Sectoral**
Financing/cost-effectiveness	*Educación Inicial* receives public financial support from the *SEP* (Public Education Secretariat) and private funding from the World Bank and IDB. Annual budgets are determined by central offices in accordance with the goals established for each state. The cost per beneficiary is reported to be US $120 per child per month, and US $114 per parent per month. Administrative costs amount to 8% of the annual program budget.	Provision of public preschool – and of public education in general – is mainly funded and managed at the provincial level (with funds delivered by the Education Services Transfer Act). In 2006 consolidated spending on education amounted to 4.7% of GDP, and no breakdown per level of education (ie: preschool, primary etc) is available. Private schools set their own rates.	Aside from exemption from national and municipal taxes, the state does not provide financial support to private schools. Public schools receive funding from the National Budget. In 2007 it was reported that 11.6% of government spending was on education. Of this, 9% was allocated to preschool education.
Service providers	The head of the compensatory programs of CONAFE manages central personnel hiring and dismissal. Decentralized coordinators manage these processes in the field. Regional units of state coordinators manage all work at the local level through their operational chains. There are 26,000 paid educational agents that work directly with parents. These agents are adults who have completed primary education, have experience in community programs for education or social development, and are able to be mobile. On average, an agent works with 10 children at a time.	A combination of public and private schools provide education services. A noteworthy difference is that private schools are capable of making decisions that affect the quality of education (ie: hiring or firing teachers). Individual public schools, on the other hand, do not have the power to determine a wide range of issues that affect the quality of education that they provide (ie: staffing decisions or contents of the curriculum). These decisions are made by provincial authorities in compliance with national regulations.	Both public and private schools provide educational services and must have qualified teachers. Early education teachers study in teacher training colleges to earn a qualification at the non-university tertiary level. In both the public and private sectors there are classroom assistants to assist in the provision of preschool education and care. Classroom assistances can be teachers and/or community members and they may have qualifications.
Quality assurance mechanisms	Internal and external evaluators assess the: program structure, participants, implementation process, contents, materials and media, and the operational chains of the program. Evaluations occur weekly or for each service provided. Reports are prepared monthly, quarterly, each semester, and annually. The World Bank and IDB conduct their own evaluations and review internal evaluations. *Educación Inicial* receives careful and frequent monitoring. Participants in this process include professionals, program coordinators, and the director. The main objective of the monitoring is to ensure timely follow-up for program improvement over time.	In the last decade a number of studies have been undertaken by private institutions, universities and international organizations. In recent years some of these studies have paid particular attention to public vs private schooling and the resulting impact on student educational indicators. Monitoring and evaluation is conducted at the state and federal level.	Preschool is subject to the quality assurance mechanisms of the ANEP. In addition, private institutions and universities have conducted studies into the impact of expanding mandatory schooling to the preschool level in areas such as student retention and failure rates. Other studies focus on the quality of education provided in both private and public schools.
Challenges for going to scale and improving service delivery	Although *Educación Inicial* is well established with a strong legal basis, improved financial support is required to ensure the program's long-term sustainability and the expansion of services.	As Argentina expands preschool coverage there is a need to invest in improving the quality of public schools.	Uruguay has made substantial progress in mandating universal preschool. Going forward the largest challenge will be improving quality of education, especially across public schools and for poor students.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

A3: Table 16. Selected Cross-Sectoral Programs in Latin America and the Caribbean

ECD Intervention	Oportunidades (Mexico)
Classification	**Cross-Sectoral**
Primary policy objective	*Oportunidades* uses a range of services including cash payments, nutritional supplements and improved access to preventative and primary health services, to increase capacities in health, nutrition and education of the most marginalized families.
Brief description	Founded in 1997 as *PROGRESA* (renamed *Oportunidades* in 2002), the intervention uses a combined parent and child strategy through cooperative agreements with health, nutrition and education services. Target ages for enrolment include pregnant and lactating women and their children from birth until secondary school (approximately 15 years old), with a particular focus on young children from birth to 24 months of age.
Focus areas/ intervention mechanisms	Transfer of cash payments to families requires that all household members visit health centers (more frequent visits for pregnant women and young children); all school-aged children attend school; an adult member of the family attends the monthly information session. In addition to cash transfers, other services include: prenatal education, childbirth support, child screening and assessments, parent education, and primary healthcare services. Food supplements are available to all children between 6 and 23 months; aged two to five who suffer from malnutrition; and to pregnant and lactating women.
Coverage/access	*Oportunidades* serves slightly more than five million families. The program is present in 93,000 districts around the county. About 99% of these districts are rural or semi-urban, and the program covers 100% of Mexico's most marginalized municipalities.
Institutional arrangements	*Oportunidades* was established with extensive legal support and has four institutions that participate at the federal level (SEDESOL; SEP; Health; and the Mexican Social Security Institute). SEDESOL is responsible for general coordination of *Oportunidades* through the program's National Coordination Agency. This agency has technical and operational autonomy and provides the 32 State-Level Coordination Agencies – whom are tasked with attending to the families and for operating and supervising the program – with the program guidelines, features, etc.
Financing/cost-effectiveness	*Oportunidades* has attracted support nationally and internationally (IDB and World Bank). In 2006, the program listed expenditures as US $1,470,932, of which 59% was provided by the Government and 41% by the IDB. The annual budget is reported to have risen to $2.7 billion in 2007. These figures exclude the provision of health and education services at the state level. Administrative costs vary between 2.4 to 3%.
Service providers	The National Coordination Agency contracts specialized financial institutions to transfer the payments to participant families. State health and education services, teachers, and health personnel provide the direct services. At the local level, participants elect *vocales* from among themselves to form community promotion committees. *Vocales'* goal is to improve the link between families and the personnel of the various services and the National Coordination Agency
Quality assurance mechanisms	*Oportunidades* conducts internal monitoring and in addition is monitored by fiscal agencies of the federal government. Monitoring reports are issued bimonthly, each semester and annually. With respect to evaluation, *Oportunidades* is the most heavily evaluated CCT program in the region. This includes annual evaluations by the National Institute of Public Health in collaboration with *Oportunidades*. Numerous evaluations have been conducted by universities and independent research institutes.
Challenges for going to scale and improving service delivery	- Social indicators for the indigenous population still lag behind, which necessitates continued attention and targeting. - Graduates of *Oportunidades* may still be disadvantaged compared to other students leaving secondary school. The program may wish to expand services to help in the transition from school to the work place.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

A4: Table 17. Selected Multi-Sectoral Programs in Latin America and the Caribbean

ECD Intervention	Madres Guías (Honduras)	Programa de Atención Integral a la Niñez Nicaragüense (Nicaragua)	Programa Primeira Infância Melhor (Rio Grande do Sul, Brazil)
Classification	**Multi-Sectoral**	**Multi-Sectoral**	**Multi-Sectoral**
Primary policy objective	*Madres Guías* program provides an array of continuous services to marginalized pregnant women and children under six to improve ECD objectives and to provide children with the opportunity to develop their abilities and skills.	*Programa de Atención Integral a la Niñez Nicaragüense* (PAININ) aims to support the psychosocial, cognitive, and physical development of poor children under the age of six.	The *Programa Primeira Infância Melhor* (PIM) aims to provide guidance to families, based on their own culture and experiences, to allow them to promote their children's holistic development from pregnancy to six years of age.
Brief description	*Madres Guías* was founded in 1992 by the Christian Children's Fund of Honduras (CCF-H). The program uses a combined strategy of parent education and child development. This approach is designed to highlight the importance of ECD and identify, select and train mothers to become community leaders who promote and develop programs of integrated ECD. In addition, the highly participatory approach of the program builds on local culture and childrearing patterns.	*PAININ* was designed in the early 1990s in response to widespread poverty. At the time there was considerable supply of services targeting high-risk children and families but they were poorly coordinated and failed to reach isolated areas. *PAININ* provides a comprehensive ECD model by consolidating delivery of services and targeting the poorest, most isolated municipalities. The program has continued to adapt and is now on its third phase (*PAININ III*).	Started in 2003 by the Rio Grande do Sol government, the *PIM* has received technical assistance from the Latin American Reference Centre for Preschool Education, UNICEF, and UNESCO. The program plays an important role in supporting families, providing them guidance and promoting the holistic development of their children. In doing so, the program adopts and tailors to the customs, traditions and cultural characteristics of the community. The program uses a multi-sectoral approach with integration among governmental departments (health, education, social services and culture). An initial diagnosis of child development along with further assessments are used to inform the planning and implementation of activities to best suit the characteristics and needs of each child/family.
Focus areas/ intervention mechanisms	The program uses several mechanisms directed to children, parents and families including prenatal education; newborn screening; child development assessments; individualized child and family development plans; early stimulation; parent education and support; nutrition services and school feeding; primary health services; social protection services; childcare and preschool education; community participation; and basic education. Services include both home visits and group sessions. Home visits are provided once a week and preschool classes are held daily for 3.5 hours.	The *PAININ* approach integrates early stimulation, health, nutrition and day-care services. *PAININ I* established a two modality approach: center-based, which serve more densely populated areas; and mobile services, for use in remote areas. Center-based provide early stimulation and preschool services. Mobile services are structured around "community base homes" from which mother-volunteers deliver in-home early stimulation and parenting skills to four or five families. In *PAININ III* a mobile preschool model was adopted where educators travel to outlying areas to deliver early stimulation and preschool services bi-weekly to children from birth to age five.	The *PIM* provides families with two modalities: individual and group care. Individual care is for families with children from birth to three years of age and pregnant women. Children are seen once a week and pregnant women bi-weekly for one hour sessions. Group care is for children aged three to six. Schedules vary and the modality includes games and playful educational activities planned by home visitors under the supervision of the *PIM* technical coordination team.

ECD Intervention	Madres Guías (Honduras)	Programa de Atención Integral a la Niñez Nicaragüense (Nicaragua)	Programa Primeira Infância Melhor (Rio Grande do Sul, Brazil)
Classification	**Multi-Sectoral**	**Multi-Sectoral**	**Multi-Sectoral**
Coverage/access	The program serves families with the highest rates of child mortality, malnutrition, and developmentally delayed children. In 2006, home visits and sessions were provided in 233 communities for parents and children from birth to three years of age, including 3,802 boys and 3,719 girls. Preschool services were offered for 1,266 children from three to six years of age and services for prenatal and post-natal education and care were provided for 890 newborns. Approximately 70% of the families live in rural areas.	*PAININ* has evolved into an integrated ECD program reaching 66 municipalities, including six on the Atlantic Coast. At the point of implementation the mobile preschool anticipated a doubling in attendance from 22,000 to 56,000 children, or 25% to 55% of children in beneficiary communities. During *PAININ II* a detailed and transparent protocol to identify localities with high rates of childhood vulnerability (defined as households with undernourished children or children not attending preschool) was established.	The PIM targets at-risk populations, such as low-income families (less than US$65 per month) and children who do not attend formal institutions. As of August 2008, the program was implemented in 225 of the 494 municipalities in Rio Grande do Sul. In total, 45,750 families were being assisted by the program, including 68,625 children and 5,490 expectant mothers receiving care during pregnancy. The goal is to expand the project to serve 100,000 children.
Institutional arrangements	The Code for Children and Adolescents of Honduras provides the legal basis for the program. At the national level, the CCF-H works closely with all levels of government, specific departments and agencies, and NGOs. Coordination is formalized through signing agreements of mutual cooperation, both technical and financial. The program employs: one central program coordinator; two regional coordinators, five supervisors, 134 parent educators, 159 community educators, and 1,926 *Madres Guías*. In each community a general assembly elects a Parents' Committee.	The Ministry of Family is the executing agency of *PAININ* through the General Program and Project Bureau (DGPP). The DGPP is responsible for the full technical, administrative and general management of the program as well as ensuring inter-institutional coordination. A basic condition for municipalities to participate in the project is that the municipal governments must sign a participation agreement with the Ministry of Family which outlines the services the municipality will commit.	The *PIM* is operated by the state secretariat of health, in coordination with the secretariats of education; of culture; and of justice and social development. The state legislature has passed a number of Decrees (ie: 42.199 and 42.200) that have had a positive impact on the program. In 2006 the program became part of state policy with the passing of law 12.544 for the promotion of ECD.
Financing/cost-effectiveness	Total funding is an estimated US $300,000 with approximately 80% provided by CCF-International. In addition, occasional grants are received from UNICEF, the World Bank, and the National Commission for Alternative Non-formal Education. Administrative costs account for 15% of the annual budget.	Since inception the program has received support from numerous international donors including: Norwegian Agency for Development Cooperation, World Bank, Central American Bank for Economic Integration, USAID, and UNICEF. Most recently, the IDB supported the third phase of PAININ with a US $15 million loan over a two year period. The Ministry of Family has reported that operating expenses represent approximately 8.4% of the investment.	Rio Grande do Sul is reported to invest approximately US $1.14 million per month in the initiative via transfers to the municipalities. In addition, the program reports contributions from the private sector, international aid organizations, and municipal governments. A complete breakdown of the programs financial structure is not available.
Service providers	The CCF-H Directorate provides technical guidelines to maintain program quality and conduct activities for planning, monitoring, supervising, and evaluating the program. Regional offices coordinate activities and projects. Local personnel train *Madres Guías*. Parents' Committees administer and implement the program and manage follow-up activities at the community level. They conduct activities for early stimulation, health, nutrition and environmental sanitation.	Depending on the location, services are provided via the center-based model and mobile services. The center-based services are staffed by educators, each of whom is required to have completed sixth grade and be 18 years of age or older. The mobiles services educators have the same requirements and travel to outlying areas to deliver services. In coordination with the communities, suitable locations are determined where the services can be provided.	The *PIM* program has modeled itself off *Educa a tu Hijo* in Cuba. There is a state technical group for overarching, program issues and municipal technical groups for selecting and training staff and overseeing execution of local actions. In total, there are approximately 1,600 home visitors employed.

ECD Intervention	Madres Guías (Honduras)	Programa de Atención Integral a la Niñez Nicaragüense (Nicaragua)	Programa Primeira Infância Melhor (Rio Grande do Sul, Brazil)
Classification	**Multi-Sectoral**	**Multi-Sectoral**	**Multi-Sectoral**
Quality assurance mechanisms	A baseline study was conducted prior to the program being implemented. Local educators monitor the program, and supervisors and specialists in the national CCF-H office review their work. Monitoring reports are prepared bi-monthly and each semester. Internal evaluations are prepared quarterly and annually. In addition, external evaluations have been undertaken. These mainly focus on the efficacy of the program objectives.	Throughout the lifespan of PAININ rigorous monitoring and evaluation has been conducted to improve the project design and effectiveness. Most recently, stipulated in the agreement with the IDB, the Ministry of Family is required to conduct extensive monitoring of all elements of the program. In addition, midterm and final project evaluations are to be undertaken.	Children are monitored every three months during their first year of life. There is also at least one annual evaluation between the ages of one and six. Internally, the *PIM* is undergoing a thorough process of monitoring and evaluation regarding its performance and achievements. Externally, the program is engaged in a Canadian Study with the Early Development Instrument (EDI).
Challenges for going to scale and improving service delivery	- The limited budget hinders the program's ability to broaden its reach and have a more profound impact. - In some instances, initial levels of parental commitment to the program have been low. The program has emphasized communication strategies to make parents aware of the numerous benefits of participation.	An ongoing challenge is the ability of *PAININ* to accurately target and reach the most marginalized children. Since the outset substantial advancements have been made to this regard with innovative approaches, such as the mobile preschool model.	Decentralization policy gives municipalities the autonomy to decide whether or not to follow state plans. Of the 323 municipalities trained by the *PIM* program, only 225 decided to execute the program. This provides an obstacle to future program expansion.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability

A5: Table 18. Comprehensive Programs in Latin America and the Caribbean

ECD Intervention	Educa a Tu Hijo (Cuba)	Chile Crece Contigo (Chile)
Classification	**Comprehensive**	**Comprehensive**
Primary policy objective	The program's objective is to achieve the maximum level of development possible for each child in areas of emotional communication, intelligence, language, motor development, health and nutrition.	*Chile Crece Contigo (CHCC)* is an integrated system of social protection for children up to four years of age with benefits, interventions, and social services to ensure that all children reach their full potential in life.
Brief description	Discussion of social policy in Cuba cannot be separated from the country's politics, cultural diversity and deeply embedded ideologies. The fall of the socialist bloc in Eastern Europe in 1989 followed by the tightening of the U.S. embargo in 1992 contributed to a severe economic crisis. At this point food became sparse, and early child indicators all deteriorated. The government responded with heavy investment in health and education, including the establishment of universal preschool education with the non-institutional *Educa a Tu Hijo* program.	When former President Bachelet was inaugurated in March 2006, she made it clear that a priority of her administration was to install a system of early childhood protection, designed to equalize the opportunities for development of Chilean children. She appointed a Presidential Commission to reach this goal, which carried out technical work and extensive consultations to lay the foundation for the design and implementation of *CHCC*. The design reflects many of the lessons and recommendations from international research and experience from effective child development programs.
Focus areas/ intervention mechanisms	The *Educa a Tu Hijo* program offers a range of services including training for pregnant women; disease prevention and health promotion; primary health care; and dental clinics. In addition, the program has specific services for each age group. The group from birth to two age receives individualized care from facilitators that visit homes once or twice a week. Children in the group from two to six age participate alongside their parents or caretakers in group sessions held once or twice a week in community spaces. During home visits systematic monitoring is carried out to evaluate children's development, and families' ability to stimulate children. Diagnosis of children's level of development is used to evaluate language and fine more skills, perception, and emotional relationships in order to establish a development profile which is used to assemble first grade classes.	*CHCC* provides coordination amongst sectoral initiatives and programs to benefit children and their biological, physical, psychological and social growth at each stage from gestation to four years of age. The level of support for all boys, girls and their families is determined by his/her specific needs. Amongst others, *CHCC* provides prenatal and birth services; day-care and preschool centers; differentiated support (ie: subsidies) for children from the poorest 40% of families; and each child receives biopsychosocial support to monitor the trajectory of their ECD.
Coverage/access	In conjunction with *Educa a Tu Hijo*, two other national programs – *círculos infantiles*, and *Salones de Preescolar* – provide early education programs to nearly 100% of children from birth to age six. Of which, *Educa a Tu Hijo* services 71%. Access is free of charge, and all children must be accompanied by a family member.	The primary target for *CHCC* is children under four years of age. In 2007, the program was deployed in 161 of the 345 communes (smallest administrative subdivision in Chile). Starting in 2008 the program began being rolled out in the remaining communities. As of the end of 2008, 473,000 children under the age of two had been incorporated into the system. During 2009 children up to the age of four were incorporated.
Institutional arrangements	*Educa a Tu Hijo* is a non-institutionalized, community-based program that is part of the National Action Plan, which was established in 1991 by Cuba and involved all of the bodies of the Central Administration of the State. The program is run by the MoE, which places the family at the center of program activities. Assemblies of peoples' power participate at the national, provincial and municipal levels.	Coordination of *CHCC* is the responsibility of the Ministry of Planning (MIDEPLAN), specifically the Executive Secretariat for Social Protection. Several others institutions are important strategic partners including: MoH; MoE; Ministry of Labour; National Women's Service (SERNAM); JUNJI; INTEGRA ; JUNAEB and the National Disability Fund (FONADIS).
Financing/cost-effectiveness	Due to the fact that the program is executed by different sectors and receives funding from the MoE amongst other bodies, it is difficult to provide a budgetary breakdown. Approximately 0.26% to 0.32% of GDP went to *Educa a Tu Hijo*.	MIDEPLAN reports that the *CHCC* had a budget of $25,388,224,000 pesos for 2009, which represents a 159% increase over 2008. At $14,231,107,000 pesos, the biopsychosocial development component is the largest. Administrative costs account for $392,510,000 pesos.

ECD Intervention	Educa a Tu Hijo (Cuba)	Chile Crece Contigo (Chile)
Service providers	Teams of promoters and facilitators carry out *Educa a Tu Hijo*. The role of promoters (primarily teachers, educators, and health professionals) is to educate the community, mobilize resources, train facilitators, and provide pedagogical guidance. Facilitators (primarily health staff and educators) are responsible for demonstrating stimulation exercises and techniques for parents and children, assessing children's development, and ensuring that families put their new skills to practice. The sessions are broken down into three periods: initial phase, intermediate phase, and closing phase. Promoters and facilitators include people from: MoE; MoH; Ministry of Culture; National Institute of Sports, Physical Education, and Recreation; family and community members; Federation of Cuban Women; amongst other sources.	The numerous interventions are provided and implemented using a comprehensive and coordinated approach that requires several public service providers. For instance, the differentiated support and guarantees component for children from the homes with low income (bottom 40% in Chile) provides services that range from livelihood training for unemployed parents to free healthcare for children with mothers who are working, studying, or who have special needs. The health sector is one more of the more important actors, with many provisions of services including the initial pregnancy consultation; prenatal and postnatal car; birth; and biopsychosocial development support.
Quality assurance mechanisms	Continuous and frequent evaluation of the *Educa a Tu Hijo* program is conducted to determine the quality of the program and its processes. Children, parents, and workers and organizations that provide services participate in the evaluations.	MIDEPLAN and the World Bank are working together to strengthen the capacity for evaluation and monitoring of social programs and policies. This includes the design of an integrated system of monitoring for *CHCC*; evaluation of the effectiveness of addressing the needs of the beneficiaries; and the completion of the evaluation of the implementation of *CHCC*.
Challenges for going to scale and improving service delivery	- One obstacle with *Educa a Tu Hijo* is that communities may have a lack of experience with programs that span sectors. To respond to this issue it is important to provide ongoing training to increase the level of quality of local participation. - Volunteers are not always available which creates logistical concerns.	*Chile Crece Contigo* is still very much in the infant stage. For this reason, many of the challenges in the near future relate to the implementation and policy adoption of *CHCC*. In particular, this involves expanding awareness of the intrinsic features of *CHCC* and they apply to children in all areas of the country.

Legend:

	low coverage / uncertain sustainability
	medium coverage / medium sustainability
	high coverage / high sustainability


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