OVERVIEW OF EARLY CHILDHOOD DEVELOPMENT SERVICES
IN LATIN AMERICA AND THE CARIBBEAN

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Social Protection and Health Division
Inter-American Development Bank

Overview of Early Childhood Development Services in Latin America and the Caribbean

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Executive Summary

This study collects and systematizes detailed, updated and comparable information about the design, management, funding and quality of child development services in Latin America and the Caribbean. It focuses on two types of programs serving children from 0 to 3 years of age and their families: (a) those that provide child care through institutional and community modalities and (b) parenting programs. Through a varied set of interventions, the two types of programs studied aim to make an impact on the environment of care that children are exposed to during a particularly vulnerable period of their lives.

In preparation for this study, we conducted a thorough process of data collection throughout 2011. Using a structured interview with at least one informant per program, detailed information was collected on a non-representative sample of 42 programs in 19 countries within Latin America and the Caribbean. In addition to the interview, during the visit to each one of the programs, it was possible to observe a few centers where services are provided, and the information collected at these observation visits was systematized. Those programs with the greatest coverage in each of the countries studied were included.

The topics examined in the report focus on the design, management and quality of the programs. The first part of the report is intended as a comparative analysis between programs and countries, while the second part provides a detailed description of the program offerings in each country visited. The main aspects explored throughout the analysis are as follows: (1) the coverage and scale of each program; (2) the manner in which these programs define their target population and the mechanisms used to target them; (3) the design of the service in terms of frequency and intensity; (4) the components or interventions that constitute the service provision model in each of the programs studied; (5) the details of food and nutrition components included; (6) information on health and safety operations and protocols; (7) information on the profiles of staff members responsible for the care of children in the program and their compensation; (8) descriptive information on recent developments in the programs studied; (9) the description of the institutional organization to which the programs belong; and (10) the cost structure.

The comparative analysis of these programs is an unprecedented undertaking in the region, from which we can highlight a few conclusions:

- Latin America and the Caribbean display tremendous heterogeneity in terms of child development programs. This is manifested in many dimensions including program coverage, services offered, available funding, the quality parameters they seek to achieve, and the profile and compensation of staff, to name a few.

- The most common modality of care in urban areas is child care services, which may be provided in institutional or community settings. Child care services constitute the modality of care with the greatest coverage in the region.

- In contrast, parenting programs that work with families, whether on an individual or group basis, predominate in rural areas.

- The supply and demand for child care services have grown in recent years, while programs offering parenting services have seen a decline in coverage.

- International evidence illustrates that the returns on investment in child

development are greater when efforts are focused on the most vulnerable groups. The region has focused most of its resources and efforts on marginalized urban populations, presumably because the majority of working women are concentrated in those areas. There remains the challenge of scaling programs to rural areas, where the highest rates of poverty are concentrated. It is likely that alternative modalities will have to be explored in rural areas.

- Child development programs seek to take a comprehensive approach; however, more work can be done to intensify this approach, particularly in terms of their nutritional or pedagogical components.

- From a social policy perspective, early childhood development programs can create a mechanism for the children they serve to also access other public services to which they or their families are entitled. The financial and political sustainability of a strategy for delivering comprehensive child development services involves taking advantage of opportunities to connect and coordinate with other sectors and stakeholders.

- Given the enormous challenge that nutritional issues continue to present in the region, through child development programs, greater efforts can be made to ensure timely and adequate nutritional support for the children participating in these services.

- In the region, there is still a long way to go in terms of defining, monitoring, and meeting quality standards on the part of providers responsible for the operation of centers offering child development services.

- Generally speaking, the care and attention of children in early childhood programs in the region fall to shorthanded, poorly-paid staff with little training. There must be investment to ensure attractive compensation and ongoing training programs.

- Guaranteeing quality child care during early childhood requires low child-to-caregiver ratios, which, inevitably, is expensive. Programs offering more services or those seeking to provide comprehensive care cost more. The average annual cost per child varies greatly among the different programs in the region.

- Providing quality child development services does not offer much in the way of political gain or votes in the short term. However, it is an investment with high returns. Therefore, political will is essential in order to contemplate reforms that guarantee access to quality services for children in Latin America and the Caribbean.

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The authors

[1] From this point onward in the study, all references to the Dominican Republic in an alphabetical list will appear in the position of the letter 'r,' corresponding to the country's name in Spanish (República Dominicana), in order to maintain consistency between this document and the Spanish-language version of the study.

1

1. Introduction

Scientific evidence has documented the importance of investing in children in the first few years of life and even before birth. When geared towards those most vulnerable, this investment yields high economic returns and avoids a widening of the gap between the rich and the poor. Comprehensive child development policies promote equal opportunities from the beginning of life. This is a key objective in Latin America and the Caribbean, as the region is characterized by the highest rates of inequality in the world.

But what exactly is comprehensive child development? Comprehensive child development involves the synergy of a set of actions that prioritizes children and their families, ensuring that their needs are met in a timely manner. This includes the areas of health, nutrition, early stimulation, education, and child care. It entails providing services directly to children but also working with their families and the community. This synergy presents two equally complex challenges: the need for intersectoral coordination and for the set of early childhood interventions to occur in a timely manner—during the first one thousand days of life, beginning at conception.

Latin America and the Caribbean face significant challenges in terms of child development. Rates of chronic malnutrition (stunting in children under 5) remain above 20% in nine of the 20 countries for which we found recent data. Even within the same country, the gaps between population groups or regions are large. In Peru, 48% of children in the poorest income quintile suffer from chronic malnutrition, as compared with 5% of those in the wealthiest income quintile. Recent evidence from five countries in the region (Schady et al., 2011) documents a dramatic gap in cognitive development between children from the highest and lowest socioeconomic levels, as measured by a vocabulary test. This study found that at 6 years of age, children in the poorest quartile have a level of vocabulary equivalent to that of 3.5-year-olds in Nicaragua, 4-year-olds in Ecuador and Peru, and 4.5-year-olds in Colombia. Yet, at the same time, the region has made significant progress in access to preschool services, which increased from 55% to 69% between 1999 and 2008, according to data from the *United Nations Educational, Scientific and Cultural Organization* (UNESCO). Even so, these figures hide considerable regional heterogeneity. In addition, the challenge remains to provide quality early childhood education services.

In recent years, many countries in the region have prioritized early childhood care on their public policy agendas. This has resulted in changes and interesting experiences in different areas. For example, in countries like Mexico, the coverage of child care services (preschools or daycares) has expanded significantly. In Jamaica, considerable efforts have been invested in improving the quality of existing preschools, and progress has been made in the process of certification, regulation and monitoring of quality standards. In Chile and Colombia, institutional reforms have been developed that improve intersectoral coordination through policies such as *Chile Crece Contigo* or the Colombian strategy *De Cero a Siempre*. Ecuador and Peru are working to improve the quality of public child care services.

Despite this progress, the region faces challenges. Coverage rates for key child development services are very low, in part because the various programs and initiatives have emerged independently of each other, without being formulated as part of a national policy on child development, and they have remained fragmented. Scant evidence about the quality of existing services suggests that it is heterogeneous and, in many cases, at

dangerously minimal levels. Low coverage and poor quality go hand in hand with the sector's meager budgets. Additionally, in most countries there are considerable deficits in regulation and administration. This means that services operated by both public and private sector entities function with little or no oversight. The training of staff with the appropriate skills to work in child development is limited, and the compensation paid does not encourage young people to get involved in this type of work. Furthermore, coordination challenges concerning this and other intersectoral social policies have not been resolved. Lastly, there are a wide variety of child development programs and initiatives that have been implemented by communities and civil society organizations, for which little exists in the way of evaluations and systematized information.

This study focuses on more thoroughly understanding the status of two types of child development services in the region: (1) child care services (known as preschools, daycares, nursery schools or child development centers) in institutional and community settings and (2) parenting services, which work with parents and families to improve their child rearing practices and early stimulation.

Most of the programs identified and studied in this document provide child care services. A large number of them were created with the primary objective of enabling women of low socioeconomic status to enter the labor force. For this reason, we present some statistics on female employment to serve as context. The region has seen major changes in female labor force participation in the last 10 years. Table 1 details the percentage of women participating in each country's workforce, regardless of the type of employment (i.e., it includes those working in the informal sector). Female labor force participation has increased significantly in most countries, intensifying the demand for child care services for the children of working mothers, particularly in urban areas. Although comparable data disaggregated by socioeconomic status is unavailable, it is the poorest women who work the greatest number of hours (Lopez Boo, Pagés and Madrigal, 2010). Additionally, it is women who work (or have worked)

Table 1. Female labor force participation in urban Latin America (women ages 15 to 64)

Country	% of female labor force participation in urban areas		% of female labor force participation in urban areas 10 years earlier
	Year	Urban	Urban
Argentina	2010	55.1	52.6
Brazil	2009	62.1	56.0
Chile	2009	50.8	45.3
Colombia	2010	64.7	61.8
Costa Rica	2010	53.7	46.7
Dominican Republic	2008	55.3	47.1
Ecuador	2010	52.9	57.1
El Salvador	2010	56.2	54.3
Guatemala	2010	51.5	57.2
Honduras	2009	50.6	54.5
Mexico	2008	49.9	42.9
Nicaragua	2010	47.3	50.0
Panama	2008	52.4	50.4
Paraguay	2008	59.6	58.4
Peru	2009	68.2	61.0
Uruguay	2009	65.5	60.3

Source: Compiled by the authors using data from IDB (2011), available at http://www.iadb.org/sociometro.

longer who most demand child care services for their children (Angeles et al., 2011). Recent evidence from Mexico indicates that the poorest women are not necessarily the main users of low-cost subsidized child care services offered by the public sector (Angeles et al., 2011), although information from Colombia's *Hogares Comunitarios* shows otherwise.

Women are not only participating more frequently in the region's labor markets (Table 1), but they are also contributing a significant portion of the income that supports their families (Table 2). Female labor force participation in urban areas increased in the last decade in every country within the region except three: Ecuador, Guatemala and Honduras. Moreover, in regard to women's contribution to household income, data reveals that in Colombia, El Salvador, Honduras and Nicaragua, women from the lowest wealth quintile in urban areas provide more than 50% of household income (Table 2), while in other countries they contribute no less than 30%. Additionally, there is a high percentage of female-headed households in the countries of this region, especially in the poorest income quintile in urban areas. Of those included in Table 2, with the exception of Mexico and Guatemala, all report that more than 30% of households in the poorest quintile are headed by women. If these women are unable to enter the labor market due to a lack of offering of child care services for young children[2], this will significantly reduce their income.

However, the availability of quality child care services for their children is not the only unmet demand for the region's working mothers. In Latin America and the Caribbean, paid maternity leave is a benefit to which only salaried workers in the formal sector have access. Women in the region with access to this right have, on average, three months of paid

Table 2. Women's contribution to household income and head of household status in urban Latin America.

Country	Year	Contribution of women to household income (%)		% of households with female head of household	
		Urban		Urban	
		Poorest 20%	Richest 20%	Poorest 20%	Richest 20%
Brazil	2009	36.7	43.2	42.2	34.9
Chile	2009	38.4	38.2	38.7	24.9
Colombia	2010	54.1	49.4	45.9	30.4
Costa Rica	2010	48.7	48.9	42.7	38.4
Dominican Rep.	2008	33.8	38.7	44.5	29.9
Ecuador	2010	34.3	40.3	35.4	24.5
El Salvador	2010	57.6	47.7	48.4	30.5
Guatemala	2010	36.5	38.4	27.7	22.5
Honduras	2009	57.1	46.4	31.4	35.0
Mexico	2008	30.8	41.6	28.9	26.5
Nicaragua	2010	53.8	44.8	39.7	39.8
Panama	2008	38.0	43.7	42.1	32.2
Paraguay	2008	41.2	42.6	38.1	28.9
Peru	2009	49.4	39.9	37.2	23.6

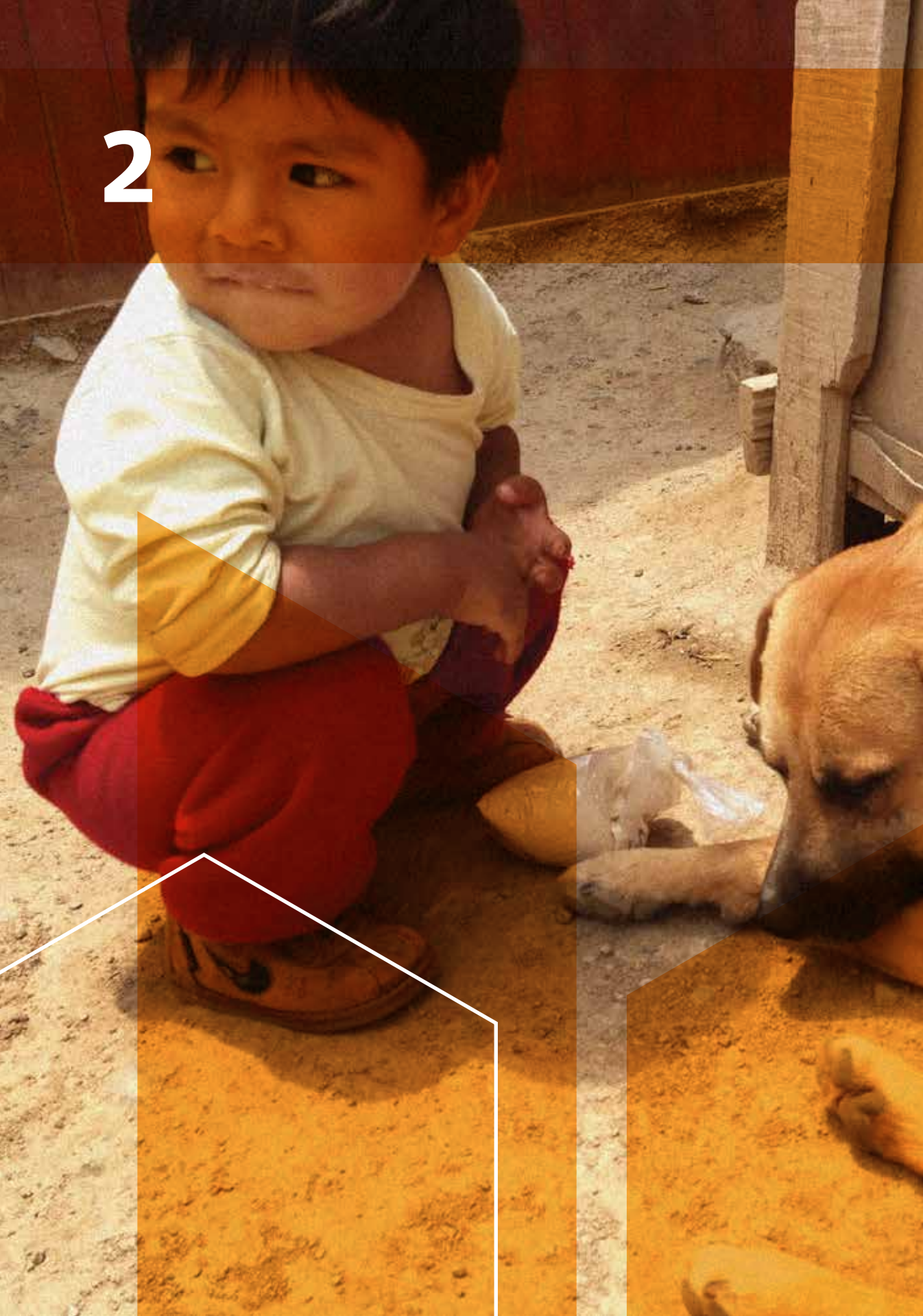
Source: Compiled by the authors using data from IDB (2011), available at http://www.iadb.org/sociometro.

[2] It is documented that the lack of supply of services (or of an additional person) for child care decreases female labor supply. A recent U.S. study (Compton and Pollak, 2011) shows that approximately 25% of women living within 25 miles of their mothers (or mothers-in-law) count on them for child care during the day, while only 4.2% of women who live more than 25 miles from their mothers receive this support. This latter group, in turn, participates significantly less in the labor market.

maternity leave.[3] The only countries that grant longer maternity leaves are Cuba and Venezuela, with 18 weeks, and Brazil and Chile, with six months (only for public servants, in the case of Brazil). In the Caribbean, maternity leave does not exceed 13 weeks, and the percentage of pay covered varies. It should be noted that the most common length of maternity leave in the region is below the minimum 14 weeks established by the International Labor Organization (ILO) Maternity Protection Convention (No. 183) (Economic Commission for Latin America and the Caribbean [ECLAC]-UNICEF, 2011). At the same time, paternity leave is almost unheard of in this region (Pautassi and Rico, 2011).

[3] In general, this period is required to begin prior to the expected delivery date.

2



2. Study Description

2.1 Objective

To meet the growing demand for child care services for young children, several countries have invested in expanding coverage through institutional or community modalities. However, in many cases, emphasis has been placed specifically on facilitating women's access to the workforce, and less attention has been paid to the need to ensure quality services that promote comprehensive child development. Against this backdrop, the motivation arose to document the current status of these programs.

The main objective of this study is to collect and systematize detailed, updated and comparable information about the design, management, funding and quality of child development services in Latin America and the Caribbean. This fulfills, at the very least, a threefold objective: first, to provide information that may prove useful for the reform processes being undertaken by several countries in the region; second, to illustrate the dimensions of program design and their management, which are critical to ensuring quality; and third, to document the operating costs of programs with different characteristics.

Box 2 describes the criteria that were used to select the programs investigated in this study. It is important to emphasize that this is not an exhaustive list of *all* of the programs of this type in the region. At the same time, this study is the most comprehensive effort to date to comparatively document the status of such services using primary sources. Other recent studies that address the subject are based on data from secondary sources (Vegas and Santibáñez, 2010) or they focus on reviewing the literature on the impact of these programs (Engle et al., 2011, 2007; Nores and Barnett, 2010; Leroy et al., 2011).

This study focuses on two types of programs serving children from 0 to 3 years of age: (1) those that provide care in institutional and community settings and (2) those that work with parents and families. The definition of the first type of service is consistent with that given by UNESCO for early childhood care and education (ECCE), which includes daycare centers, daycare in private homes, preschool, pre-kindergarten, kindergarten, playgroups, and hourly child care (Kamerman, 2006). Parenting services work with families and caregivers of children, either individually or in

Box 1. Congruence with IDB social strategy

The purpose of this study is congruent with the priorities of the IDB's Strategy on Social Policy (2011). Within the specific field of child development, the IDB's Strategy establishes two main objectives:

a) For children ages 0 to 3: Identify policies and interventions that support parents and caregivers in improving the quality of care, ensuring access to comprehensive child development services for vulnerable populations, and identifying effective, high-quality modalities of service, with low drop-out rates and sustainability in the long term.

b) For children ages 4 to 6: Expand access to preschool services, taking into account issues of quality and equity, and strengthen initiatives that coordinate preschool education with the primary education cycle.

In addition, the IDB Strategy on Social Policy seeks to support countries in the tasks of reviewing and reforming the processes of selection, certification, and training of staff employed at early childhood care services.

Box 2. Programs surveyed

The programs selected to participate in the study were those that met the following requirements:

Public funding (central or local government) and, in a few exceptions, programs of civil society organizations (*Roving Caregivers* and *Kallpa Wawa*) or in association with the private sector (the Early Childhood Care and Education Centers of Trinidad and Tobago), whose inclusion was based on the broad coverage they achieve
Care for children 0 to 3 years of age (without excluding those that *also* serve older populations)
Interventions that make an impact on the quality of the environment and the care received by the children
Types of programs included:

- Child care centers (institutional or community settings)
- Programs that work with families, fathers and mothers on issues related to parenting and stimulation (through home visits or group meetings)
- In addition, two initiatives were included from services typically geared towards health, which incorporate some component of intervention with parents on parenting issues and stimulation (specifically, *Desnutrición Cero* in Bolivia and *Programa de Atención Integral a la Niñez – AIEPI/AIN-C* in Honduras)[4]

groups, to improve parenting and child rearing practices, stimulation and the quality of interactions between parents and children. The element that the two types of programs have in common is that, through their interventions, they make an impact on the environment of care that children are exposed to during a particularly vulnerable period of their lives—the first three years of life (although most of the programs studied *also* serve older children).

2.2 Literature review

Comparative analysis of services in the region

There are relatively few studies that systematize comparative information on the design, management and quality of early childhood development programs in Latin America and the Caribbean. Evans, Myers and Ilfeld (2000) gather examples of best practices, articles and useful information about a variety of topics including planning, modalities, infrastructure, evaluation, and funding for the staff responsible for the management and operation of child development programs. Naudeau et al. (2010) looks to support policy dialogue on early childhood development and, to that end, systematizes information on technical issues in an easy-to-read format. Their work reviews the literature on the impact of early childhood development services and programs as well as instruments that measure development. The issue of funding for child development services is addressed in Grun (2008), who examines the characteristics of five funding models used in developed countries.

Vegas and Santibáñez's book (2010) focuses on Latin America and the Caribbean and reviews the characteristics of some of the region's major early childhood programs in the areas of health, education and nutrition. A background study was performed as part of the preparatory work for that book, and it has been systematized in two different papers (Vargas-Barón, 2007 and 2009). It contains a more detailed review of the design and operational characteristics of 10 programs in the region, whose target population is children ages 0 to 5. A great variety of programs are included: conditional cash transfers, health interventions, child care, and programs that work with parents through home visits. Since these studies use rather broad selection criteria in terms of program types and they include a limited number of them, they fail to provide a systematic comparative analysis of the early childhood development services offered in the region.

[4] These two programs are not included in the comparative analyses, as their characteristics are very different; however, they are analyzed in detail in section 4.

Impact of child care services in Latin America and the Caribbean

A recent study by Leroy, Gadsden and Guijarro (2011) performs a meta-analysis of evaluations on the impact of changes to the delivery of child care services, using methods that control for potential self-selection among individuals who choose to participate in such programs. The authors conducted an exhaustive search of the literature from 1980 onwards and found only six studies that met the established methodological criteria. These studies corresponded to five countries in the region, with one each in Bolivia, Guatemala, Argentina, and Uruguay, and two in Colombia. They combine two types of care modalities: institutional and community. In general, the evaluations reveal positive effects on measures of child development in the short and long term for those who participate in these services from 36 months of age. However, due to inconsistent results, it was not possible to draw conclusions regarding the impact of these programs on health and nutrition. Of these six studies, only the one that focused on *Hogares Comunitarios de Bienestar* (HCB) in Colombia (Attanasio et al., 2010, Bernal et al., 2009) evaluated the impact of the service on children's health. This study found significant reductions in the prevalence of diarrhea and acute respiratory infections in children who had attended the program for a longer period of time. However, these effects could be associated with an increase in infections in children immediately after starting at a HCB, since the comparison group was made up of children who had recently begun attending (and not with children who did not participate in the HCB). At the same time, the authors find no consistent effect of the program on immunization rates or child nutrition. In the same vein, the assessment of another child care service, *Programa Integral de Desarrollo Infantil* (PIDI) in Bolivia, also failed to find an impact on children's growth (Behrman et al., 2004). For its part, the evaluation of Guatemala's *Hogares Comunitarios* (Ruel et al., 2006) did identify a clear positive impact on children's diets as a result of program attendance.

With regard to the effect of these services on other aspects of child development, literature in the region also yields mixed results. For example, the evaluation of the HCB in Colombia finds that, in the short term, the frequency of aggressive behavior among children in the program increased, although isolation was reduced and appropriate social interactions increased. Importantly, improvements were also noted in the cognitive development of children in the areas of language, mathematics, and general knowledge. These effects on cognitive development also appear to persist in the long term. Similarly, the study on PIDI in Bolivia cited above found short-term effects on children's motor development, language and psychosocial skills. Another recent study by Veramendi and Urzúa (2011) finds that Chilean daycares make a positive impact on the development of children over two years old. These findings are consistent with those from a previous study led by Contreras (2007), who recognized that children attending Chilean preschools perform better on achievement tests once they enter elementary school. Lastly, the impact assessment of PAININ in Nicaragua (Santiago Consultores, 2010) finds that program attendance has no effect on children's development.

The findings of positive impacts of daycare attendance on cognitive and social development are consistent with other assessments that have focused on identifying long-term effects of preschool attendance in Argentina (Berlinski et al, 2009) and Uruguay (Berlinski et al, 2008), where these services are offered on a large scale. These two studies found positive effects on school test scores, children's behavior, school attendance, and years of schooling. In his own right, Rodrigues et al. (2011) examines data from Brazil, and he verifies that preschool attendance improves fourth-grade test scores.

One deficiency of several of the aforementioned studies identifying positive effects of attending daycare is that they have very limited information about the channels through which the impact occurs. Apart from the explanation of improved diet in the case of Guatemala, none of the studies investigates the mechanisms through which the impact of programs offered by child care services occurs. Moreover, evidence of the low quality of the services described, which

is also documented in studies such as those done on Guatemala and Colombia, suggests that these programs are far from achieving their potential impact.

Impact of parenting services in Latin America and the Caribbean

The second form of intervention studied in this document consists of those programs that work with families to improve the quality of care and stimulation that children receive in their first years of life at home. The existing literature (Baker-Henningham and López Boo, 2010; Engle et al., 2011) shows that in countries like Israel, St. Lucia, Turkey, Jamaica, Ecuador, Cuba, South Africa and Brazil, the impacts of these home visits were positive and sustained over time. In addition, these interventions are cost-effective, particularly when: (1) the intensity is high (e.g., weekly visits have greater impact than monthly visits); (2) the quality is good (i.e., there is a considerable initial and ongoing effort to train staff, accompanied by monitoring and supervision processes and the existence of detailed protocols); (3) exposure to the program is long-term; (4) the focus of the intervention is clear (e.g., stimulation vs. education); and (5) the process between the teacher/home visitor and the family is interactive.

The most recent and rigorous assessments, conducted in Jamaica (Walker et al., 2005) and Colombia (Attanasio et al., 2012), are based on the implementation of this type of program on a pilot basis. The impact assessment of Jamaica's program identified substantial short- and long-term effects on children whose parents participated in a home-visit program focused on improving early stimulation. At baseline, the children who participated in this pilot suffered from chronic malnutrition and were between 9 and 24 months of age. The visits lasted for 24 months and were performed weekly. The impact of these visits has manifested itself through improved academic, work, and social results, which persist even into adulthood. For its part, the Colombia program promoted weekly home visits to encourage psychosocial stimulation in children who, at the start of the intervention, were between 12 and 24 months old. After 18 months of program participation, they found significant positive impacts on their cognitive and language (receptive and expressive) development, as well as improvements in the quality of the home environment. The impacts were greater among children who entered the program at 19 months of age or older. It is worth mentioning that, in the region, there is no rigorous impact assessment on this type of service implemented to scale.

Cost-effectiveness of child care services

Methodologically similar to the present study, though focused on the United States, Helpburn's book (1995) analyzes the costs, quality and measurements of child development from a random sample of 100 daycare centers in California, Connecticut, Colorado and North Carolina. This study presents comparisons of the centers in terms of the type of services provided, their organizational and administrative structure, the characteristics of the physical space, the mechanisms of parental involvement, the use of volunteers, and staff policies. It also analyzes in detail the cost structure, subsidies, income sources, and the payment by families for services (if applicable).

The most relevant results of the Helpburn study are that the quality of daycare centers that serve children ages 0 to 3 years, i.e., the target group of the present study, is, at best, mediocre. More than half of the children sampled in this age group attend centers with quality levels that do not meet minimum standards. The study also finds that the quality of services is better in centers that have the following characteristics: lower child-to-caregiver ratios; caregivers with higher levels of education, more training opportunities, and better wages; administrators with more years of experience; better developed curricula; and lower staff turnover. The study found that even mediocre-quality centers are very expensive. Interestingly, in the US study, higher-quality centers appeared to cost just 10% more than the mediocre ones.

2.3 Methodology

In order to document the state of child development services in the region, in

2011 this study implemented an ambitious process of gathering information about the programs. The collection and analysis of information that supports this study can be organized into four stages: (i) the development of questionnaires and observation protocols, (ii) programs visits, (iii) follow-up to obtain missing data, and (4) systematization and analysis of the information collected.

This study was designed as a qualitative analysis, organized around the completion of a structured interview with at least one informant per program. The first step was to develop instruments for the interviews with program directors. The topics to be covered in these meetings were program design, funding, organizational and managerial aspects, and quality variables.[5] The main modules of the questionnaire for the program director are shown in Table 3. In most cases, it was possible to conduct the interview with the actual program directors or coordinators. It is worth noting that these were not the directors of individual centers but rather those in charge of supervising a program or *network of centers*. Despite the wealth of information collected during the interview, it is important to mention that this approach also has limitations. For example, it occurred many times that the information reported was based on the standards the program strives to meet rather than its actual operation. Given the nature of an interview, it is impossible to verify *all* of the information provided. Lastly, not all of the programs possess equally systematized, current, or complete data on certain topics. In particular, there was heterogeneity in the reporting of financial information and information related to compliance with health and safety standards.

In addition to the interview with the program coordinator, a visit to some of the centers was requested to observe the operation of the services. In order to systematize the information gathered during these visits, in addition to the aforementioned questionnaires, instruments were developed to systematically code the observations.[6] In practice, it was only feasible to visit one or two centers per program. The programs selected the centers to be visited, which probably implies a bias, as they wanted to showcase the most successful service providers.[7] Still, the use of coded observations proved useful to validate the information reported by administrators. It also made it possible to observe the services' operating characteristics, to dialogue with operators and teachers-caregivers, and to verify quality measures (such as child-to-caregiver ratios or the educational profile of teachers and caregivers). Table 4 summarizes the main issues addressed during these observations.

Over the course of nine months, visits to 42 programs that agreed to participate in the study were organized in 19 countries.[8] Given the qualitative nature of this research, there was no random selection of programs or centers since geographical, racial and socioeconomic status representation was not intended. What was achieved was to have the programs with the greatest coverage represented in each of the countries.

With that said, it must be recognized that there were programs that were identified too late and therefore were not included in the calendar of visits, for example, the *Centros de Desarrollo Infantil* in Nicaragua (serving 6,500 children in 55 extended daycare centers) and *Centros Educativos Culturales de Infancia* de la JUNJI in Chile (serving children ages 2 to 6, with an emphasis on artistic and cultural expression). In countries such as Brazil and Argentina, where the delivery of these services is decentralized to the state or municipal level, it was impossible to visit more than a very small sample of the available offering.

Most visits were made by the same person, one of the authors of this study.[9]

[5] The questionnaire is available at: http://www.iadb.org/ProteccionSocial
[6] These are available at: http://www.iadb.org/ProteccionSocial.
[7] Even so, the authors themselves were surprised at the conditions found in some centers (e.g., dirty bathrooms, pots boiling within the reach of children just learning to walk, bare wires, adult-child interactions that lacked warmth, etc.).
[8] Refusals to participate in this study were low and occurred in just one country.
[9] One of the authors was responsible for almost all of the visits, with the exception of those made to programs in Paraguay, Argentina, and Trinidad and Tobago, which were performed by another author.

The surveys and the instrument for coding observations were piloted in Jamaica. After that experience, several adjustments were made. Interviews with program directors were carried out successfully, despite their length and level of detail. On average, they took four hours per program, but there was a great deal of variability. The interview tended to last longer in cases where the program's information was not systematized.

Table 5 shows the list of countries and programs visited, specifying the cities where the program headquarters are located, their service areas (national, municipal), and the parent institution. As a complement to Table 5, Table 6 specifies the name and title of the informant who was in charge of answering the main questionnaire for each program. The two tables are organized alphabetically by country.

Since there was information that was unavailable for systematization during program visits, it was necessary to perform individual follow-ups, by telephone, to complete the questionnaires. For the most part, the information obtained in this phase dealt with financial data, details about staff educational profile and salaries, as well as the breakdowns of some programs' coverage. Despite these efforts, it was not possible to collect information on all program variables for every program included in the study, which is why, in several of the tables presented below, the number of observations does not match the total number of programs visited.

Table 3. Modules and components of the assessment questionnaire for early childhood programs.

Instrument	Module	Information Type	Detail
Assessment Questionnaire for Child Development Programs in Latin America and the Caribbean	General Characteristics of the Program	Identification	Program identification
			Identification of people interviewed
		General Characteristics of the Program	Program history
			Services provided
			Targeting
			Hours of operation
			Coverage
	Administration	Administration	Information about the program's board of directors
			Channels of representation
	Quality	Infrastructure and Supply	Type of facilities used in the activities
			Regulation of spaces
			Regulation of equipment
		Health and Safety	Regulation of safety
			Regulation of health
		Information Systems and Interaction with Parents	Information on the children
			Work with the parents
			Copayments
			Preventive and emergency procedures
		Human Capital	Profiles
			Salaries
			Reasons for care
		Inclusion	Inclusion policy for children with disabilities
			Inclusion policy for indigenous and immigrant children
		Perception of the Services	Mothers' preferences
	Curriculum	General Characteristics	Date created and components of curriculum
		Nutritional Support	Monitoring of development
			Provision of food
			Menu creation
			Food services staff
			Provision of micronutrients
	Prospects	Plans and Limitations	Future plans
			Main limiting factors
	Financial Summary	Total Income	Sources of income
		Total Expenditures	Expenditure categories
		Annual Cost per Child	Final calculated cost per child

Source and preparation: the authors.

Table 4. Modules and components of instrument to code observations during visits to service providers.

Instrument	Module	Information Type	Detail
Observation Protocol – Child Care Services	Identification	Center Identification	Name and program to which it belongs
		Director Identification	Director's name and training
	General	Enrollment Process	Description of the process
		Waiting List	Exists? If so, number of children on it
		Copayments and Funding	Prices and funding sources
		Schedule Flexibility	Flexibility and discretion in scheduling
		Perception of the Services	Mothers' perception
	Surroundings and Infrastructure	Proximity to Public Transportation	Ease of public transport and noise produced
		Condition of Surrounding Area	Presence of elements that negatively affect the children
		State of the Center	Ventilation, presence of graffiti, attractive exterior
		Basic Spaces	Outdoor playground
	Bathrooms and Kitchens	Adequate Equipment	Adequate sinks and toilets
		Water Service	Present? If so, ease of water access
		Hygiene	Soap, diaper changing area, garbage cans
		Condition of the Bathrooms	Plumbing, leaks and cleanliness
		Condition of the Kitchens	Safety, restrictions, and equipment
	Play, Learning and Quiet Areas	Children enrolled	Number of children and age group
		Staff	Number of teachers, aides and other staff
		Adequate Equipment	Presence of toys, book and materials
		Spaces	Sufficient space for activities
	Interactions and caregivers	Schedule	Hours per day and days per week
		Participation	Children's participation and activity in general
		Interactions	How the teachers and children interact
Instrument	**Module**	**Information Type**	**Detail**
Observation Protocol – Parenting Programs	General Information	Visit type	Individual or group session, number of families
		Identification of Interviewee	Name and profile of person in charge of the session
		Session Location	Type of location where session is held
		Length	Session length
		Copayments	Program costs
	Supervision	Presence of Supervisor	Presence at the session and frequency of attendance
		Role of the Supervisor	Interaction with the peer educator
	Location and Facilities	Proximity to Public Transportation	Ease of public transport and noise produced
		Condition of Surrounding Area	Presence of elements that negatively affect the children
		Hygiene	Diaper changing area, garbage cans
		Conditions of the Bathrooms	Drinking water, cleanliness
	Play and Learning Areas	Adequate Equipment	Presence of toys, book and materials
		Spaces	Sufficient space for activities and safety
	Interactions and caregivers	Schedule	Days of the week and months of the year
		Participation	Children's participation and activity in general
		Parent-Child Interaction	How the parents and children interact
		Condition of the Children	Clothing and appearance of the children

Source and preparation: the authors.

An attempt has been made to carefully document this issue in each of the tables.

The rest of the study focuses on analyzing the design, funding, administration, and quality aspects of the programs studied. Since differences exist in Latin America with regard to the origin and evolution of these types of programs across different groups of countries, occasionally the

analysis is broken down into subregions: the countries of the Andean region, the Southern Cone, and Central America. As a subregion, the Caribbean is discussed briefly in Box 14. In this study, the Caribbean is treated almost as a case study since information is only available for Jamaica and Trinidad and Tobago.

Box 3. Comparative analysis of the curricula

In an effort to gather information on the programs studied, original documents containing the program curricula and early learning guidelines were collected from those programs in possession of them and willing to share. The comparative analysis of the curricula is, in itself, a significant undertaking. Moreover, it requires a different methodology. For this reason, it was decided to perform this work in parallel with the execution of this study. The comparative analysis of early learning guidelines (ELGs) seeks to identify and characterize the commonalities and differences between the curricula examined. Curricular material was collected for 27 programs from 14 of the countries surveyed. As with this paper, the focus of the comparative analysis of the ELGs lies in children 0 to 3 years of age (and, in some cases, their families).

Given the heterogeneity of the curricular data to be examined, a comparative analytical assessment methodology was employed, which systematizes a wide range of domains and indicators present in each of the documents. These indicators are the ones that describe the learning standards set out in the respective documents. The method of analysis is based on the work of Scott-Little et al. (2008), which assessed ELGs for children ages 0 to 3 in a sample of U.S. programs. This analysis is presented in a separate document accompanying this study: "Early childhood learning guidelines in Latin America and the Caribbean" , written by Christine Harris-Van Keuren and Diana Rodríguez-Gómez of Columbia University.[10]

Box 12 summarizes the main findings of this study in greater detail.

Table 5. Programs visited

Country	City	Program	Institution to which program belongs	Type
Argentina	Buenos Aires	Centros de Protección Infantil	Ministry of Social Development (Buenos Aires)	Municipal
Argentina	Buenos Aires	Jardines de Infantes de la Ciudad de Buenos Aires	Ministry of Education (Buenos Aires)	Municipal
Argentina	Buenos Aires	Programa Nacional Primeros Años	National Council for Social Policy Coordination	Municipal
Argentina	Villa Paranacito	Jardines Infantiles de la Ciudad de Villa Paranacito	Ministry of Education (Province of Entre Rios)	Municipal
Bolivia	Cochabamba	Kallpa Wawa	UNICEF and the Municipality of Tapacari	Municipal
Bolivia	El Alto	Programa de Atención a la Niñez - Manitos	Government of La Paz – Municipality of El Alto	Municipal
Bolivia	La Paz	Desnutrición Cero	Ministry of Health	National
Brazil	Fortaleza	Atención en Educación Infantil	Secretariat of Education (Fortaleza)	Municipal
Brazil	Rio de Janeiro	Espacio de Desarrollo Infantil	Secretariat of Education (Rio de Janeiro)	Municipal
Brazil	Sobral	Proyecto de Primera Infancia	Municipal Secretariat of Education (Sobral)	Municipal
Chile	Santiago	Conozca a su Hijo-CASH	National Board of Day Care Centers	National
Chile	Santiago	Fundación Integra	Ministry of Education/Office of the First Lady	National
Chile	Santiago	Jardines Infantiles de la JUNJI	National Board of Day Care Centers	National
Colombia	Bogota	Hogares Comunitarios de Bienestar Familiar	Colombian Family Welfare Institute	National

[10] Available at: http://www.iadb.org/ChildDevelopment

Country	City	Program	Institution to which program belongs	Type
Colombia	Bogota	Infancia y Adolescencia Feliz y Protegida Integralmente	Secretariat of Social Integration (Bogota)	Municipal
Colombia	Medellin	Buen Comienzo	Secretariat of Education, Health and Social Integration - Medellin	Municipal
Costa Rica	San Jose	CEN-CINAI	Ministry of Health	National
Ecuador	Quito	Centros Infantiles del Buen Vivir-CIBV	Institute for Children and Families	National
Ecuador	Quito	Creciendo con Nuestros Hijos-CNH	Institute for Children and Families	National
El Salvador	San Salvador	Modelo de Atención Integral	Salvadoran Institute for the Comprehensive Development of Children and Adolescents	National
Guatemala	Guatemala	Hogares Comunitarios	Secretariat of Social Work of the First Lady	National
Guatemala	Guatemala	Proyecto de Atención Integral a la Niñez	Directorate-General of Education Quality Management - Ministry of Education	National
Honduras	Tegucigalpa	Bienestar Familiar y Desarrollo Comunitario	Honduran Institute for Children and Families	National
Honduras	Tegucigalpa	Programa de Atención Integral a la Niñez - PAIN-AIEPI/AIN-C	Secretariat of Health	National
Jamaica	Kingston	Early Childhood Comission	Ministry of Health	National
Jamaica	May Pen	Roving Caregivers	Rural Family Support Organization	N/A
Mexico	Distrito Federal	Guarderías	Mexican Social Security Institute	National
Mexico	Distrito Federal	Programa de Educación Inicial	National Council for Educational Development (CONAFE)	National
Mexico	Distrito Federal	Programa de Estancias Infantiles	Secretariat of Social Development	National
Nicaragua	Managua	Programa de Atención Integral a la Niñez-PAININ*	Ministry of the Family	National
Panama	Panama	Centros de Orientación Infantil y Familiar	Ministry of Social Development	National
Panama	Panama	Programa de Estimulación Precoz	Panamanian Institute for Special Needs	National
Paraguay	Asuncion	Programa Nacional Abrazo	National Secretariat for Childhood and Adolescence	Municipal
Peru	Lima	Centros de Desarrollo para la Integración Familiar-CEDIF	National Institute for Family Welfare	National
Peru	Lima	Programa Nacional Wawa Wasi*	Ministry of Women and Social Development	National
Dominican R.	Santo Domingo	Espacios de Esperanza	Office of the First Lady	National
Dominican R.	Santo Domingo	Estancias Infantiles Salud Segura	Dominican Social Security Institute	National
Dominican R.	Santo Domingo	Programa de Atención Integral a la Primera Infancia	National Council for Children and Adolescents	National
Trin. and Tobago	Puerto España	Early Childhood Care and Education Centers	Ministry of Education	National
Uruguay	Montevideo	Plan CAIF (Centros de Atención Integral Familiar)	Uruguayan Institute for Children and Adolescents (INAU)	National
Uruguay	Montevideo	Programa Nuestros Niños	Government of Montevideo	Municipal
Uruguay	Montevideo	Programa Primera Infancia (Centros Diurnos)	Uruguayan Institute for Children and Adolescents (INAU)	Municipal

*Note: the PAININ and Wawa Wasi programs were replaced by other interventions after being visited in 2011.
Source and preparation: the authors.

Table 6. People interviewed and their titles.

Country	Program	Name	Title
Argentina	Centros de Protección Infantil	Santiago López	Director-General for the Strengthening of Civil Society
Argentina	Jardines de Infantes de Buenos Aires	Marcela Goenaga	Director of Early Childhood Education
Argentina	Jardines Infantiles de Villa Paranacito	Marta Muchiutti	National Director of Early Childhood Education
Argentina	Primeros Años	María Liliana Gamarra Norberto Vázquez	Technical Coordinator Monitoring and Assessment Coordinator for Primeros Años
Bolivia	Pan-Manitos	Víctor Rodríguez David Santamaría	Head of the Health Programs and Insurance Unit Program Manager
Bolivia	Kallpa Wawa	Ludmina Colque Lidia Zambrano	Municipal Assistant for Human Development Supervisor
Bolivia	Desnutrición Cero	Lucy Alcón Vladimir Camacho	UNI Supervisor Head of the Quality Health Services Unit
Brazil	Atención en Educación Infantil Fortaleza	Francisca Francineide de Pinho	Early Childhood Education Coordinator
Brazil	Proyecto de Primera Infancia de Sobral	Julio César Alexandre Edna Lucia de Carvalho	Secretary of Education (Sobral) Early Childhood Education Coordinator
Brazil	Espacio de Desarrollo Infantil - Rio de Janeiro	Eduardo de Padua Nazar	Special Projects Manager
Chile	Fundación Integra	Patricia Paredes Johnny Chamorro	Chief of Strategic Alliances Staff Accounting Support Professional
Chile	JUNJI	Sylvana Meniconi	Director
Chile	CASH	Sylvana Meniconi Mafalda Díaz	Director CASH National Program Manager
Colombia	Buen Comienzo	Fabián Zuluaga Mauricio Hoyos	Director Care Cost Manager
Colombia	Secretaria de Integración Social	Paola Londoño Adriana Velázquez	Children's Social Services Coordinator Day Care Center Team Leader
Colombia	Hogares Comunitarios de Bienestar	María Patricia Serra Rey	Head of the Office of Cooperation and Contracts
Costa Rica	CEN-CINAI	Guillermo Flores	Executive Director
Ecuador	CIBV	Javier Cueva Elizabeth Ramos	National Early Childhood Coordinator Advisor
Ecuador	CNH	Javier Cueva Elizabeth Ramos	National Early Childhood Coordinator Advisor
El Salvador	Modelo de Atención Integral	Sonia Molina	Head of the Department of Early Childhood Care
Guatemala	Hogares Comunitarios	Patricia Castañeda	Community Homes Program Director
Guatemala	Programa de Atención Integral a la Niñez	Edna Torres Ilse Secaira	Department of Early Childhood Education Professional Deputy Director of Academic Education
Honduras	Bienestar Familiar y Desarrollo Comunitario	Aleyda Girón Josué Martínez Oviedo	IHNFA Technical Assistance Manager National Coordinator
Honduras	PAIN	Concepción Durón	Head of PAIN
Jamaica	Early Childhood Comission	Winsome Johns-Gayle Michelle Campbell	Executive Directo Director, Sector Support Services
Jamaica	Roving Caregivers	Utealia Burrell	Executive Director of RUFAMSO
Mexico	Estancias Infantiles para Madres Trabajadoras	Lizbeth Torres	Director of Inter-institutional Relations
Mexico	Guarderías de la Seguridad Social	Nabiha Sáade Jorge Govea	IMSS Day Care Coordinator Head of the Service Expansion Division

Country	Program	Name	Title
Mexico	Programa de Educación Inicial - CONAFE	Valerie Vonwobeser Imelda Velázquez	Deputy Director of the Early Childhood Education Program Technical Support Staff
Nicaragua	PAININ	Lucía Padilla Reina García	National Assistant for Early Childhood Education Finance Clerk
Panama	Centros de Orientación Infantil y Familiar	Julián Rivera Angélica Pérez	National Director of Social Protection Services Supervisor
Panama	Programa de Estimulación Precoz	Gloria Hernández Itzel Palacios	Director of Early Learning Program Director-General of the IPHE
Paraguay	Abrazo	Norma Duarte Luis Bendozo	Director of Protection and Promotion of the Law Director of Center #2
Peru	Programa Nacional Wawa Wasi	Josefina Vera Capurro Sandra Manrique Becerra	Manager of the Planning and Development Unit Instructor Specialist
Peru	CEDIF	Carmen Jordán Vela Juan Ramón Ugarte	Management Assistant Monitoring Assistant
Dominican R.	Espacios de Esperanza	Carolina Gordillo	Manager of Children's Projects
Dominican R.	Programa de Primera Infancia	Penélope Melo Ruddy Lozano	PAIPI Manager Finance Manager
Dominican R.	Estancias Infantiles de la Seguridad Social	Lilliam Rodríguez	Education Director
Trin. and Tobago	Early Childhood Care and Education Centers	Ann Thornhill Keisha Mahabirsingh	Director Account Clerk II
Uruguay	Plan CAIF	Susana Mara Andrea Tejeira	Director-General of Early Childhood Division Director
Uruguay	Programa Nuestros Niños	Brenda Rovetta María Mangado	Executive Coordinator Technical Team
Uruguay	Programa de Primera Infancia del INAU	Rosario Martínez Adela Telles	Director, Division of Childhood Director-General of Early Childhood Programs

Source and preparation: the authors.

3

3. Comparative analysis of the programs

3.1 The origin of child development services in the region

The first early childhood care and education services in Latin America appeared in the late 19th century, but it was not until the mid-20th century that public programs offering early childhood services really began to take root. An illustrative example of this is the *Jardines de Infantes* program in Argentina. In the late 19th century, the first nursery school opened in the city of Buenos Aires; however, comprehensive nursery schools, as they were called, which focused primarily on children 5 years of age, were not established until the 1930s and 1940s. In those days, nursery schools functioned in classrooms adjacent to elementary schools. During the 1950s, with an increase in industrialization and migration to urban areas, nursery schools became more popular, setting off a process of expansion. These services were the forerunners of the provincial programs that exist today in Argentina, which provide not only preschool services but also care for the youngest of children (referred to as *Jardines Maternales*).

The date of establishment of the child care programs researched in this study precedes parenting programs by almost a decade. The child care programs have been operating, on average, for 22 years, albeit with a rather wide range of variability. Interviews were conducted with some programs that began their activities in 1930 and others that just got underway in 2009. The average age of parenting programs in the region is nearly 12 years (Table 7). An examination of the differences between subregions highlights that child care services began to appear, on average, about 25 years ago in Central America, the Caribbean and the Southern Cone, whereas in the Andes, this type of modality has existed, on average, for just 16 years (Table 8). In more than one country, anecdotal information collected from program directors links the establishment of these programs with

Box 4. The history behind the founding of these programs

Junta Nacional de Jardines Infantiles ***(JUNJI) – Chile***
JUNJI represents a typical example of the institutional care model (nursery and preschool), whose presence is common, especially in the Southern Cone. In Chile, public preschools begin to emerge in the early 1970s, in response to the need for women to enter the labor market. Although coverage was low back then, this institution came into being with a pioneering range of comprehensive child care services in Latin America that included nutrition and food services (serving an important role at that time in terms of tackling the malnutrition that existed in those years), education and care. Since 1985, the process to expand coverage has been supplemented by alternative services (e.g., stimulation, nursery schools, etc.), and processes to improve the regulation of preschools have been initiated. In 2005, new regulations were adopted for variables critical to quality of care such as child-to-caregiver ratios and the minimum qualifications that must be met by teachers. Quality improvement processes in Chile make today's JUNJI nursery and preschools an important regional reference.

Hogares Comunitarios de Bienestar ***(HCBs) – Colombia***
Community Welfare Homes (HCBs) are a representative example of community child care services, which are common in Andean countries. In 1974, *Hogares Infantiles* were created in Colombia to facilitate the entry of economically-disadvantaged mothers into the labor market and to provide a safe place for children in urban areas affected by violence. In 1988, as part of a large-scale government strategy to eradicate poverty, the *Instituto Colombiano de Bienestar Familiar* (Colombian Family Welfare Institute – ICBF) extended the coverage of the *Hogares Infantiles*, calling them HCBs. In recent years, the ICBF has undertaken a number of efforts to improve the quality of care at the HCBs and to transition from a community modality

to an institutional one. This process involves, among other changes, the construction of new infrastructure and the hiring of professional staff responsible for the children's care. Training processes with community mothers, the bulk of the program's staff, have also begun. HCBs currently constitute the community child care service with the largest coverage in Latin America, serving more than 1.2 million children.

CEN-CINAI – Costa Rica
CEN-CINAI is representative of parenting programs that operate out of health centers. The program focuses on nutrition, but it also has components of early stimulation. Its initial objectives were to provide nutrition services to low-income families. Care began in 1949 with the support of UNICEF and in coordination with the Department of Nutrition of the Ministry of Health. In the 1950s, the first *Centros de Educación y Nutrición* (CEN) were built, where nutrition workshops were held and food was distributed. In 1971, the program began integrating early childhood education into its objectives. In 1975, the *Centros Infantiles de Nutrición y Desarrollo Infantil* (CINAI) were created. In 2010, this initiative was strengthened by the consolidation of the two programs into the *Dirección del CEN-CINAI*.

Plan CAIF – Uruguay
This program began operating in 1987 as an experimental pilot program of UNICEF. The project's aim was to ensure high-quality interactions with children, family and community, as well as to provide nutrition services and comprehensive care. During the 1990s, coverage expanded through the opening of new CAIF centers. The program later came under the auspices of the Uruguayan Institute for Children and Adolescents (INAU), within the Ministry of Social Development. To intensify the expansion process, operating agreements were signed with different types of institutions including preschools, religious institutions, the Army, cooperatives, NGOs, and trade unions. Although this strategy proved successful in terms of expanding coverage, operating by way of agreements weakens uniform operating standards. For this reason, in 1997, a unique structure was created for the centers, with a kindergarten program and a curriculum developed by the Ministry of Education and Culture.

policies that aimed to facilitate women's access to the labor force.

The first experiences related to early childhood education and care had different motivations. In some cases, early childhood care services were aimed at the working class, which did not have sufficient financial resources so as to keep children at home until they were old enough to go to primary school, while in others cases, the children with access to preschool belonged to high-income families and they attended institutions affiliated with private schools (UNESCO, 2010). Box 4 documents in more detail some representative trajectories of different types of programs that were collected during interviews with program managers.

One thing that stands out when analyzing the history of the creation of the programs studied is that these services were designed from the very start with different visions. In some cases, they are based on the provision of educational services, while in other instances, they serve as a support service for poor families in order to facilitate labor force participation and income generation by adults. The latter approach usually neglects the educational component of child care services and places less emphasis on the processes of training and skill-building in the staff responsible for the care and attention of the children.

3.2 The expansion of early childhood care and education in the region

The expansion of early childhood education and care services was relatively slow until the 1970s. Previously, early childhood education and care facilities were generally located in large cities where the concentration of children was higher, and they were usually attached to a primary school (UNESCO, 2010). However, in order to facilitate mothers' entry into the labor force, child care programs expanded into urban slums, hospitals, industrial areas and other places with a high concentration of families with children.

Nonetheless, the supply of these services was still very limited in the late 1980s, and the majority of children entering primary school had not had

Box 5. Preschool coverage

Although this study focuses on services that meet the needs of children ages 0 to 3 years rather than preschool programs, it is worth noting that since 2000, progress in preschool coverage[11] has been significant in Latin America and the Caribbean. In 2004, the gross enrollment ratio at early childhood education and care centers was high compared to other regions of the world with similar levels of development, although lower than that reported by developed countries. While the average ratio in developing countries was less than 50%, it reached 60% in Latin America, and in the Caribbean, total coverage was achieved (Vegas and Santibáñez, 2010).

By the late 2000s, Latin American countries like Argentina, Ecuador, Mexico, Uruguay, and Venezuela reported an enrollment rate for pre-primary levels above 80%. At the same time, other countries such as Paraguay, El Salvador, Nicaragua and Honduras were lagging behind, with less than half of children enrolled in preschool (Schady, 2012).

Despite the improvement in coverage, inequality in access to preschool education remains a drawback. For example, in El Salvador, the percentage of children enrolled from the lowest wealth quintile was about half of that of children in the highest quintile. In Brazil and Nicaragua, the gap between the first and fifth quintile was 27 percentage points (Schady, 2012). Meanwhile, access in countries like Uruguay, Costa Rica and Argentina seems to be more equitable.

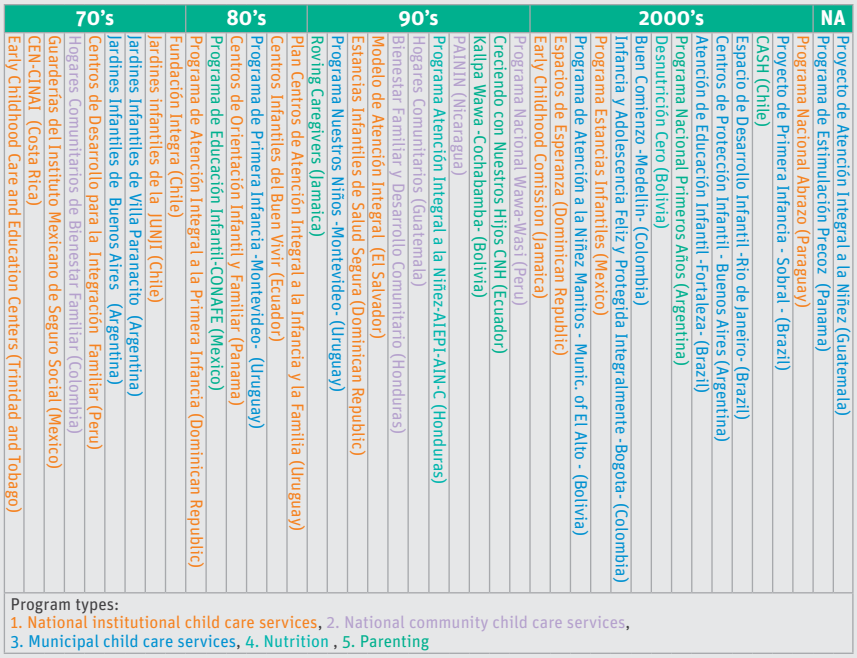
previous access to a child care service or kindergarten. The coverage of early childhood services in Latin America and the Caribbean has increased significantly, especially in the last two decades. Coverage of early childhood education and care for children aged 0 to 5 years increased from 7.9% in 1980 to 15% in 1986. Many countries in the region recorded significant increases, including Brazil (91%), Costa Rica (85%), the Dominican Republic (233%) and Mexico (133%). Most of the increase in coverage was associated with significant efforts to universalize education levels prior to primary school. Later, between 1985 and 1995, UNESCO reported a large increase in coverage in the region. For example, the enrollment rate at early childhood education and care facilities jumped from 83% to 96% in Chile, from 76% to 81% in Jamaica, and from 8% to 19% in Trinidad and Tobago (Kamerman, 2006). It is worth noting that these figures mainly reflect the expansion of preschool services for children over 3 in the region. Coverage for children below this age continues to be significantly lower in the region.

According to the World Education Forum, between 1990 and 1998, the number of children aged 3 to 5 years attending an early childhood education or care facility increased significantly, reaching a coverage level of almost 50% for children in this age group in Latin America and the Caribbean. In the Caribbean, progress has been faster. It is estimated that currently, 95% of children in Jamaica are served by early childhood education services offered from 3 to 5 years of age. The increase observed in the region is in line with a greater awareness of the importance of early childhood education by parents and greater attention to the issue by governments.[12] In some countries, informal or community programs have enjoyed a greater degree of acceptance and expanded more rapidly, while in others, institutional or more formal programs have acquired a greater presence (Kamerman, 2006).

Figure 1 illustrates the timeline for the establishment of the programs studied within their current institutional structure, and it classifies them according to service type and level of government under which they fall. This report makes a distinction between child care services and parenting programs. However, a distinction is also made in Figure 1 as to whether the modality is institutional or community-based (i.e., those child care services that function in spaces annexed to schools or in a center designed specifically for child care, with a hired staff vs. those that function in homes,

[11] Keep in mind that, in general, statistics regarding preschool attendance mainly consider formal programs aimed at children about to enter elementary school, excluding, in many cases, informal or community programs that have some education component but are classified as "child care" and, therefore, treated separately (Myers, 1992).
[12] More and more countries in the region (Argentina, Colombia, Chile, Paraguay, Peru, Uruguay and Venezuela) have adopted early childhood education policies. This shows that the issue has garnered more attention on the public policy agenda.

Figure 1. Timeline for the establishment or consolidation of the program, according to service type and level of government



* Programs listed under NA on the timeline are classified as such due to uncertainty about their start date.
Source and preparation: the authors.

with volunteer staff or staff who receive financial compensation without having a contractual relationship with the program) plus the level of government, in order to have finer detail about these services before they are re-grouped for analysis. Here is the breakdown: a) 16 national programs that provide child care services through institutional modalities, b) five national programs that provide child care services through community modalities, c) 13 municipal programs that provide child care services, d) two nutrition programs, and e) six parenting programs (one of which is municipal). It is worth mentioning that several of the programs in their current form were created during the 1970s, as is the case of the first national early childhood education and care services in Chile, Costa Rica, Mexico, Peru, and Trinidad and Tobago. In addition, the first community homes program in Colombia was created during this decade. It was also during this time that Argentine daycare and preschool programs (in existence since the 1930s) were decentralized to the municipal level.

In the 1980s, the Dominican Republic, Panama and Uruguay implemented their national programs. In addition, the municipal early childhood program in Montevideo and the first parenting program in Mexico began in this decade.

In the 1990s, Guatemala and Peru promoted community programs, Honduras implemented a national program and a parenting program, Nicaragua created a national program, and Bolivia started a parenting program with weekly meetings for indigenous children.

Since the year 2000, the municipal programs analyzed in Bolivia, Colombia and Brazil have been created, as well as the national program in Jamaica and the program for street children in Paraguay. In that decade, Argentina launched its parenting program, Mexico began a subsidized child care service using third-party providers *(Estancias Infantiles)*, and Bolivia created the *Desnutrición Cero* nutrition program. Beginning in 2006,

early childhood development became a public policy priority in Chile, with coverage for child care expanding to 93% for children under age 2 belonging to families in the first two income quintiles whose mothers work, study, or seek employment and require institutional child care services. Additionally, Chile created a comprehensive child care policy known as *Chile Crece Contigo*, which was passed into national law. Lastly, in 2009, the Dominican Republic launched a new national program, and Argentina and Brazil consolidated additional municipal programs.

It is worth noting that the early childhood education and care services model that the region has adopted combines public and private service delivery. The public sector has an important role as a direct provider, especially in rural areas and among the lowest socioeconomic levels. For example, in Chile, most of the coverage is financed by public funds, by way of two funding strategies managed through JUNJI and INTEGRA, with 100% of operating costs transferred to NGOs, religious congregations, and municipalities (the private sector offering in Chile accounts for less than 10% nationally). Moreover, in most countries, the government plays some sort of role in terms of administering the private sector offering. In countries such as the Dominican Republic, a significant portion of the supply of early childhood education and care services falls under the responsibility of the private sector, while in other countries such as Brazil and Costa Rica, these services are provided primarily by the public sector (Kamerman, 2006). In countries such as Jamaica and Ecuador, the delivery of publicly-funded services is performed by private entities (churches, communities, or nonprofit organizations) that supplement public funding with contributions from families.

The delivery of child development services operates at the central level in two-thirds of the countries in the region. In some countries, the responsibility has been transferred to local governments. Today, a third of the programs visited operate at the municipal level. However, there are significant differences between countries. For example, the majority of the countries (including the Dominican Republic, Trinidad and Tobago, Costa Rica, El Salvador, Nicaragua, Panama, Mexico, Honduras, Ecuador, Peru, Chile and Guatemala) have programs that offer institutional or community-based child care services with national coverage. Meanwhile, in Bolivia, Argentina and Brazil, child care services are organized at the municipal level. For their part, countries such as Colombia and Uruguay combine offerings from different levels of government, both national and municipal.

Bolivia, Argentina, Jamaica, Honduras, Mexico, Ecuador and Chile all have parenting programs. In Bolivia, this program operates in only one municipality, as in Jamaica, where it is a non-governmental initiative (described in depth in Box 7). In the other countries, parenting programs depend on the central government.

3.3 Coverage and scale

It is a challenge to characterize the public supply of early childhood programs in the region, especially in light of their heterogeneity. For this reason, the presentation begins with some general information about the coverage and scale of the programs researched. Of the 42 programs interviewed for the study, 34 (81%) were programs that provide institutional or community-based child care services, two (5%) were nutrition programs, and the remaining six (14%) were parenting programs. Ten of the 42 programs studied (24%) correspond to the Andean region, 14 (33%) to the Southern Cone, 15 (36%) to Central America, which for the purposes of this study also covers Mexico and the Dominican Republic, and the remaining three (7%) to the Caribbean. The remainder of the study will focus exclusively on the 34 programs that provide child care services and on the six parenting programs, i.e., a sample of 40 programs. Nutrition programs are excluded from the analysis, as they exhibit significant differences from the rest of the programs studied in terms of their goals and the interventions they provide.

Table 7 presents some variables in the scale of the sample. On average, among the programs studied, those providing parenting services attain coverages with more than double the number of beneficiaries of those providing child

care services (207,900 versus 89,800 children). It is worth noting that, in both cases, there is considerable variability in the range of coverage values. At the same time, the average size of the staff for the two types of programs is of a more similar magnitude—just over 7,700 employees for parenting programs and 11,800 employees for child care services. This is explained by the very nature of the two types of services. Parenting programs operate less frequently, for shorter periods, and with less intensity child care services at centers. In contrast, center-based child care programs, for the most part, offer this service on a permanent, year-round basis, which permits the mothers of the children who attend these programs to work.

Table 8 examines the data from programs that provide child care services (in institutional or community settings), disaggregating it by subregion. Based on this data, it would appear that the greatest average total coverage of these programs is in the Andean region, followed by Central America, and lastly, the Southern Cone. However, the information presented is skewed, given that in Argentina and Brazil, two countries with broad coverage for these types of services nationwide, the supply of these services is decentralized and, therefore, the data collected during visits to a few units (provinces in Argentina and states in Brazil) do not allow for totals representative of the national level.[13] There is yet another fact to consider. The average size of the Andean programs is inflated due to the presence of the Community Welfare Homes program in Colombia, the largest in the region. In the absence of this program, the average number of children served by programs that provide child care services is similar in the Andean region and Central America (i.e., excluding HCBs, this average is reduced from 222,000 to 56,000 in the Andes).

Greater coverage for child care services in the Andean region is also reflected in the existence of a larger number of centers in this region than in the other. On average, the programs visited in the Andean region have over 11,000 centers (1,518 if you exclude the HCBs) under their operation or supervision, which is 19.1 times more than the Southern Cone programs and 10.4 times more than the Central American programs (2.5 and 1.3 times more, respectively, excluding the HCBs).

In terms of staff employed by these programs, on average, the programs in the Andean region employ more than 17,900 persons, in other words, a number 4 and

Table 7. Descriptive statistics of the sample by program type.

Region	Child Care Services		Parenting	Nutritional	Total
Andean	7		2	1	10
Southern Cone	12		2	0	14
Central America	13		1	1	15
Caribbean	2		1	0	3
Total	**34**		**6**	**2**	**42**
Child care services					
Variable	Observations	Mean	Standard Dev.	Missing	Not Applicable
Program Age (Years)	34	22.3	16.8	0/34	0/34
Number of Children Served in 2011	34	89,818	210,249	0/34	0/34
Number of Centers in 2011	34	3,350	12,453	0/34	0/34
Total Employees in 2011	32	11,828	28,820	2/34	0/34
Parenting					
Variable	Observations	Mean	Standard Dev.	Missing	Not Applicable
Program Age (Years)	6	11.7	9.90	0/6	0/6
Number of Children Served in 2011	6	207,991	228,660	0/6	0/6
Total Employees in 2011	6	7,750	12,305	0/6	0/6

Source and preparation: the authors

[13] To illustrate this point, the coverage of public preschools in each Argentine province is considered, and the population served from the 0 to 5 age group is added together. Using this calculation, it turns out that service coverage *nationwide* is 1.5 million children.

0.9 times the corresponding value for the Southern Cone and Central America, respectively (if the HCBs are excluded, the Andean programs employ over 7,700 people, or 1.7 and 0.4 times the Southern Cone and Central American figures). It is important to highlight that the variables presented in this section (number of children, number of staff, and number of centers) are the components with which child-to-caregiver ratios are calculated, often cited in the literature as a key structural variable to measure the quality of such services. This issue is discussed later in more detail.

If the totals at the bottom of each group of indicators are observed and the average size of each facility, by region, is calculated by dividing the number of children served for the total of operating centers, one can see that the average size of each day care center differs significantly between subregions. Centers are 2.5 times larger in Central America (48 children per center) than in the Andes (19) and 1.3 times larger than in the Southern Cone (36). This difference in scale is also present when looking at the size of program staff. Programs in Central America have, on average, 14.3 employees per center, while the Andes and the Southern Cone have only 1.5 and 3.4 employees per center, respectively. These disparities have an explanation. As seen below, a significant portion of the supply in Central America corresponds to the *Guarderías* del Instituto Mexicano de Seguridad Social, with centers of a much larger scale than other programs in the region.

It is worth noting that programs on a national scale and those at the municipal level probably face different challenges in their operation and management, precisely due to the issue of scale. The management of municipal programs may be more vulnerable to the processes of local initiatives and the policies of the sitting mayor, which means they may face the threat of being discontinued by subsequent governments. However, their smaller scale probably allows them to more efficiently solve specific problems in the communities they serve. Furthermore, it is important to mention that in the Southern Cone, the supply is almost

Table 8. Descriptive statistics of the sample by region.

	Observations	Mean	Standard Dev.
Andean			
Program Age (Years)	7	15.6	13.6
Number of Children Served in 2011	7	222,850	441,599
Number of Centers in 2011	7	11,627	26,862
Total Employees in 2011	7	17,902	28,187
Total No. of Children Served in the Region (2011)	7	1,559,950	N/A
Total No. of Centers in the Region (2011)	7	81,388	N/A
Total No. of Employees in the Region (2011)	7	125,314	N/A
Southern Cone			
Program Age (Years)	12	23.7	20.1
Number of Children Served in 2011	12	46,285	54,999
Number of Centers in 2011	12	1,271	3,109
Total Employees in 2011	12	4,430	4,934
Total No. of Children Served in the Region (2011)	12	555,417	N/A
Total No. of Centers in the Region (2011)	12	15,252	N/A
Total No. of Employees in the Region (2011)	12	53,160	N/A
Central America			
Program Age (Years)	13	24.6	15.7
Number of Children Served in 2011	13	61,773	86,278
Number of Centers in 2011	13	1,118	2,499
Total Employees in 2011	11	18,145	43,693
Total No. of Children Served in the Region (2011)	11	678,600	N/A
Total No. of Centers in the Region (2011)	11	13,871	N/A
Total No. of Employees in the Region (2011)	11	199,594	N/A

Source and preparation: the authors.

exclusively institutional in nature, while in the Andes and, to some extent, Central America, a community-based model prevails.

Since the study identified just six parenting programs in the 19 countries visited, it makes no sense to present these statistics disaggregated by subregion. Parenting programs are more common in rural areas, where a child care service may be impractical due to the geographic dispersion of households. This is precisely one reason why parenting programs face major operational challenges. In rural areas, it may be more difficult to recruit qualified staff. Similarly, the dispersion makes it more expensive to invest in training and supervision and to ensure consistent quality for the service provided. Some of the challenges facing these programs are discussed in Box 6.

The variability in the coverage of the programs studied is illustrated more clearly in Figure 2 and Figure 3. Figure 2 focuses on programs that provide child care services, and it distinguishes the different subregions with colors, while Figure 3 focuses on parenting programs. In Figure 2, programs operated by municipalities are highlighted with an asterisk to distinguish them from those whose operation is the responsibility of the central government. In Figure 3, the asterisk identifies programs that are not publicly funded but instead are initiatives that depend on civil society organizations or international donors and that operate in specific municipalities on a very small scale. The *Roving Caregivers* program (described in more detail in Box 7) and *Kallpa Wawa* are small-scale parenting programs that operate in Jamaica and Bolivia.

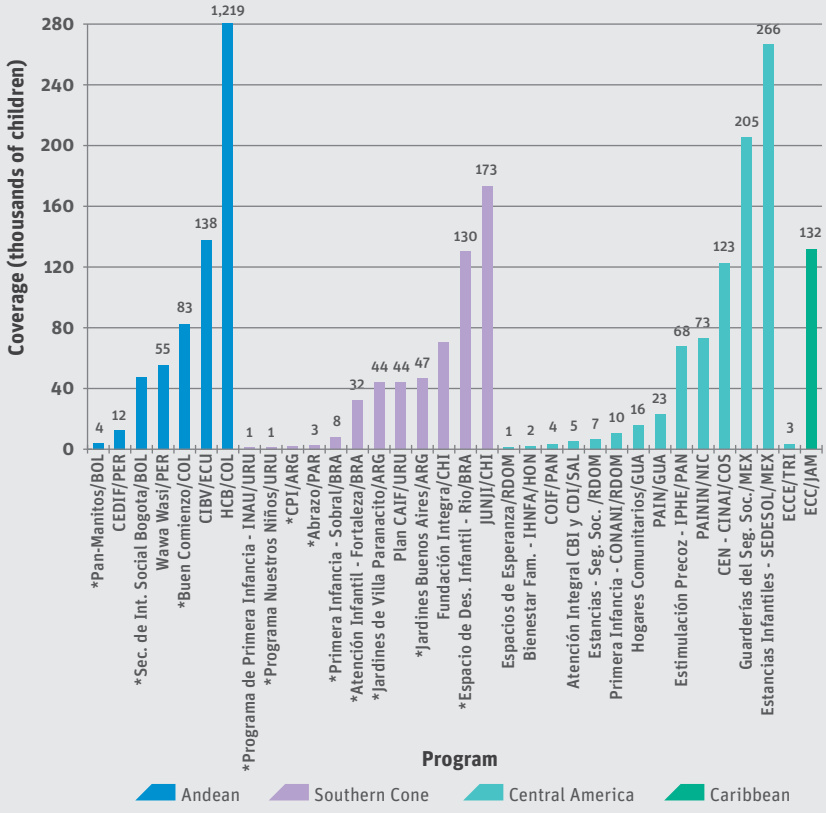
Box 6. Parenting programs

Within programs that provide institutional or community-based child care services, there is almost always some component of the intervention that involves parents. Paraguay's *Programa Nacional Abrazo* is a very unusual example in this regard and in others (see Box 8). However, this intervention is never as intense as in those programs that focus solely on parenting. Work with parents is conducted mainly through two modalities: home visits to individual households in order to work with the mother or primary caregiver of the child, or periodic group meetings in a community space. In these meetings, families are trained on issues related to the care, upbringing, or psychosocial stimulation of children. Generally, a curriculum is followed, and there is an activity plan/agenda for each meeting. In programs with one-on-one interaction, topics relevant to the child's age are covered. This approach is not possible when working with groups of families with children of different ages.

Programs that work with parents, families or caregivers are characterized by having lower operating costs than programs that provide child care services. In general, a single community worker or home visitor is in charge of working with eight to 15 families. Depending on the modality of care and the number of households a community worker is responsible for, the frequency of care may be weekly or biweekly. Each session lasts from one to two hours, although the community worker must devote additional time to prepare for and document each meeting. Usually, these programs do not provide food or nutritional supplements to their beneficiaries. Furthermore, given that they use the physical space in homes or take advantage of the space in community centers, their infrastructure maintenance costs and utilities payments are minimal. Community workers do not typically have a formal employment relationship with the program but they do receive a modest payment for their work.

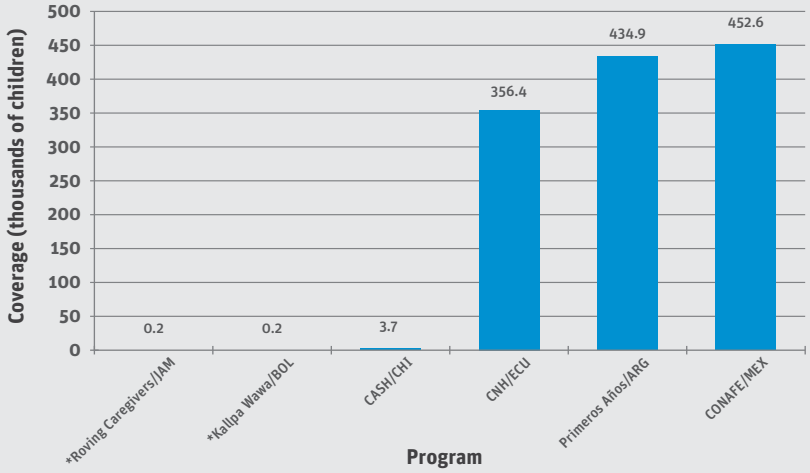
One feature of this type of program is that it is better suited to the reality of scattered rural populations; however, these programs face considerable operational challenges. On one hand, it can be difficult to find and train suitable personnel to conduct these sessions effectively in rural, scattered contexts. Programs seek community workers that have credibility and leadership skills, as well as good communication skills and the ability to build rapport with families. One limitation of these programs is that they require a time commitment from the families (usually the mothers). In rural areas, it can be difficult to find a time to bring together mothers or groups of mothers whose work routine includes not only household chores and caring for their children but also agricultural work or other productive activities. In practice, it often happens that these programs fail to maintain high attendance or participation rates over time. This is not a minor issue. Without regular contact between the community worker and the mother, these types of interventions prove mostly ineffective at changing deep-rooted behaviors and beliefs in parents, such as those related to parenting, child care, and the interaction between them and their children.

Figure 2. Coverage of programs that provide child care services



Note: The names of the programs whose operation depends on municipal rather than national government are highlighted with an asterisk.
Source and preparation: the authors.

Figure 3. Coverage of programs that provide parenting services



Note: The programs marked with an asterisk are operated by civil society organizations with funding from international donors and function on a small scale in specific municipalities.
Source and preparation: the authors.

Coverage of child care services (in institutional and community-based modalities) varies greatly among the programs studied. The smallest are programs such as *Espacios de Esperanza* in the Dominican Republic or *Nuestros Niños* and *Programa de Primera Infancia (Centros Diurnos)* in Uruguay, which serve just 1,000 children. At the other end of the spectrum, we have the program with the greatest coverage in the region, the *Hogares Comunitarios de Bienestar* (HCBs) in Colombia, a single program that serves more than 1.2 million children.

Among parenting programs, *Kallpa Wawa* in Bolivia, which serves just 200 children and their families, stands out as the smallest in coverage, while at the other extreme is the PEI-CONAFE program in Mexico, which covers more than 450,000 children and their families.

3.4 Targeting

This section compares the methods used by child development programs for selecting beneficiaries. One fact that stands out is the programs' own perception of the characteristics of the target population they seek to serve and its size. When program directors are asked to calculate the percentage of the target population that they are actually serving, the heterogeneity of responses is large. Of the programs that provide child care services, about two-thirds feel that they serve less than half of their target population, while the remaining third serves more than half of it. For their part, of the six parenting programs for which this information is available, four reveal that they serve less than a quarter of their target population, while two, *Primeros Años* in Argentina and CNH in Ecuador, reach 50% and 68%, respectively, of the population they aim to serve. Interestingly, those programs with larger coverages are the same ones that feel that they serve a larger percentage of their target population. The relationship between these two variables is illustrated in Figure 4.

It is worth noting that the percentage of the target population served was a variable reported by the programs during the interview and, in many cases, calculated without supporting data. For this reason, it is interpreted as an approximation to the programs' *perception* of the challenges they face in terms of under-coverage. In other words, it allows for an understanding of how the programs quantify the percentage of the population they manage to reach at their current scale, with respect to the population that potentially meets the criteria to be served by them. In subregional terms, the programs of the Andean region, on average, achieve greater coverage of their target population (45%), followed by the Southern Cone (40%) and, lastly, Central America (27%). To summarize, throughout the region, there is a common perception that large coverage gaps persist for such services.

The survey administered to program directors collected systematic information about the criteria and type of information they use to determine a family's eligibility for use of their services. Table 9 describes the frequency with which certain criteria are identified by child care programs as those that guide the selection of beneficiaries. It is worth noting that programs use different *combinations* of criteria, which Table 9 looks to summarize. The data in this table show that the most frequently used criteria for targeting are the conditions of poverty and social risk and the presence of a working mother. Just two programs explicitly identify geographic area as a targeting criterion (since they only serve

Box 7. The Roving Caregivers Program of Jamaica

The *Roving Caregivers Program* works directly with parents in May Pen, Jamaica, and it is run by the Rural Family Support Organization with funding from UNICEF and the Bernard van Leer Foundation. It began in 1996 as a training program for young people who had dropped out of school. It later became a pilot program for teenage mothers, and it trained the first generation of community workers. This modality has expanded into several countries in the Caribbean. At its peak, the Jamaican Program had 50 community workers and served more than 1,200 children, but in 2008, foreign donors cut funding for the project, which led to a drastic reduction of staff. In March 2011, the Program had just eight community workers and one supervisor.

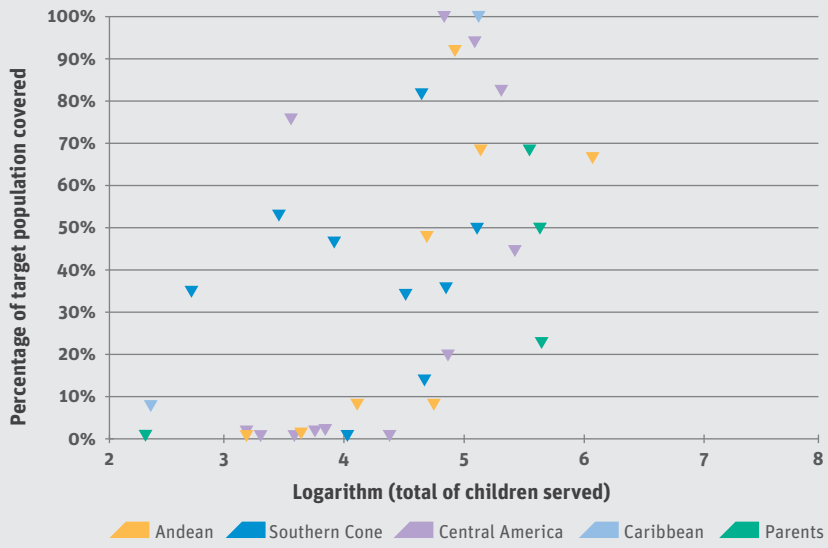
the marginal urban population). This stands out since, in practice, the vast majority of programs providing child care services prioritize urban areas where there is a low population density that makes it feasible to operate.

Data from Table 9 also reveals that around one third of programs providing child care services identify the malnutrition status of children as a targeting criterion. Only one of the programs visited exclusively devotes itself to serving children with special needs (and it provides specialized services, different from those of other programs visited). Finally, there are a few cases where child care services aim for universal coverage. No program was identified that specifically targeted minorities. Box 8 describes the rather unique experience of a Paraguayan program whose attention is geared toward street children.

Table 10 summarizes the targeting criteria for parenting programs. In this group, the variables used most often to select beneficiaries also include poverty and social risk. Five of these programs explicitly limit their activity to rural areas. This makes sense, as this type of program is usually implemented in scattered populations where the main child care environment is the home and where it would not be cost-effective to set up a child care service. For this reason, the presence of a working mother in the home is not a relevant targeting criterion for any of these programs. It is worth noting that in two of the six cases studied, minority status is recognized as a targeting criterion for parenting services.

Thus far, the criteria used by the programs to identify their target population have been analyzed. For example, socioeconomic status is one of the most common, since most of the early childhood development programs studied seek to prioritize care for poor households. However, the key question is how do the programs convert those targeting criteria into an operating procedure? In other words, what tools do the programs have to transform an intention (to give priority to care for the poor) into an action? It is the effectiveness of these tools that determines whether or not the programs reach their target population. Since the 1990s, many Latin American countries have developed sophisticated targeting systems that are used in the operation of various social programs. For example, conditional cash transfer programs typically make use of these systems. In some countries, the conditional cash

Figure 4. Target population served and program coverage



Source and preparation: the authors.

Box 8. *Programa Nacional Abrazo, Paraguay*

Programa Nacional Abrazo is an emblematic experience of the Paraguayan government's National Secretariat for Children and Adolescents (considered ministerial level). Its target population consists of street children. For this reason, the Program places a lot of emphasis on maintaining interaction with families.

Since its inception in 2005, the program has served as a safety net for street children ages 0 to 14. It provides comprehensive care, stimulation, nutrition, health care, and, in cases of extreme poverty, a subsidy to the child's family (in part to replace the income that the child brought home before entering the program).

Currently, the program has 19 centers and 2,700 children, 740 of whom are between the ages of 0 and 4. Although coverage is lower than that of other programs in the region, its target population makes this level significant. The program faces challenges in terms of the quality of its infrastructure; however, its teachers have a high professional background, and it has the longest school day/hours of operation of all the programs considered, at 15 hours a day, six days a week.

In addition to child care services at the center, *Programa Nacional Abrazo* has a special parenting component. Once children have completed a cycle of care at the center, follow-up with the parents or primary caregiver is performed on a monthly basis, where care, teaching and learning methods, nutrition, health and development issues are addressed, with attention similar to that of parenting programs.

transfer program develops and manages its own targeting system. However, in other countries, the targeting system does not reside with any one program but rather it is an instrument available to different public sector entities for the selection of beneficiaries. This is the case of the systems in Colombia, Ecuador and Peru, to name a few examples. Targeting systems combine statistical methodologies with the gathering and updating of a household census to identify those who fall below one or more poverty lines. Box 9 describes this type of system. Although countries have invested significant resources in developing these instruments, in many cases, they are still underutilized. For example, countries such as Ecuador and Peru could more systematically integrate the beneficiary selection process for child development services with their targeting systems (the Social Registry and the Household Targeting System [SISFOH], respectively), as is done in Colombia.

Table 9. Combinations of targeting criteria for programs that provide child care services.

List	Universal	Poverty	Social Risk	Malnutrition	Working Mothers	Minorities	Special Needs	Area (urban/ rural)	None	Frequency
1		X	X							6
2		X	X	X						4
3	X									4
4		X								3
5		X			X					3
6		X		X						2
7		X	X		X					2
8		X	X	X	X					2
9		X	X					X		2
10									X	1
11					X					1
12			X				X			1
13			X		X					1
14		X	X							1
15	X				X					1
									Total	**34**

Source and preparation: the authors.

Table 10. Combinations of targeting criteria for parenting programs.

List	Universal	Poverty	Social Risk	Malnutrition	Working Mothers	Minorities	Special Needs	Area (urban/ rural)	None	Frequency
1						X		X		2
2		X	X					X		2
3			X					X		1
4		X								1
									Total	**6**

Source and preparation: the authors.

The survey administered to child development programs researched the type of instruments used by programs to operationalize their targeting. That is, how—based on the criteria described above—they identify and select their beneficiaries. For example, programs were asked if their method of assessing the poverty of a household applying to participate in their service is to collect information on household income or, conversely, to evaluate other socioeconomic characteristics of the families in order to build some sort of wealth index with that data (which is known as a socioeconomic file). Similarly, we identified those programs that use a targeting system not affiliated with the program but administered by another government agency for the selection of their beneficiaries. Another targeting channel explored was the geographic location of the centers, which, by self-selection and under the assumption that they would serve the surrounding population, can serve to prioritize attention to certain groups.

Table 11 systematizes the information collected on this subject. In 24 of the 34 programs that provide child care services, a socioeconomic file is used to assess the household situation (in 13 cases it is the only instrument and in the rest it is used in conjunction with another instrument). These socioeconomic files are, with few exceptions, developed by the programs themselves. They include some categorical variables that identify specific variables for the households that should receive priority attention. Five programs combine the use of the file with a geographical criterion guided by the location of their centers. Meanwhile, three programs use only the geographical location of their centers as the mechanism through which they expect their beneficiaries to come to them. Six programs were also identified that, in addition to the socioeconomic file, collect information on family income to select the recipients of their services. Lastly, five programs reported that they use no system to verify the eligibility of their beneficiaries (and rightly so for four of them, whose aim is to achieve universal coverage of the population). For programs without a targeting system that determines priority in the selection of beneficiaries, spaces are usually allocated according to the order they are registered for the service. Given that even those programs whose goal is to achieve universal coverage do not succeed, a quota allocation system based on first come-first served may result in the neediest families missing out on spaces. Universal coverage programs are discussed in greater detail in Box 11. For its part, Box 10 summarizes the main barriers to entry faced by families who want access to child care services, from the point of view of the operators of these programs.

The case of parenting programs is unique. Since they specialize in serving rural areas, it is common for beneficiaries to be selected with a first round of geographic targeting (by identifying priority areas) that is supplemented with a socioeconomic file.

Although this study presents only a global look at the selection process for beneficiaries of child development programs, there are contradictions in the information collected, particularly in regard to programs that provide child care services. On one hand, the programs acknowledge that the fundamental criteria that identify their target population are poverty, social risk and the presence of working mothers. However, most programs make relatively little use of

geographic instruments to guide targeting decisions by way of service location. The geographic targeting instruments appear to have underutilized potential for the programs studied, since poverty, risk and labor force participation are important variables whose distribution reflects patterns of spatial heterogeneity. Furthermore, there is abundant evidence that documents that proximity to child care services is a clear determinant of its demand. It is also worth highlighting that early childhood development services could be better linked to national targeting systems that operate in many countries of the region and that determine eligibility for other social programs targeted at the poor, such as conditional cash transfers. This thought suggests that there is room for improvement in terms of targeting systems for child development programs so that they can fulfill their own goals more effectively.

3.5 Frequency and intensity of service

This section examines the frequency and intensity with which the programs studied offer their services. We examined both the number of months per year during which the programs function as well as their operating schedule. This information is summarized in Table 12.

On average, programs that provide child care services operate daily for a period of 8 hours per day. In some cases, the number of hours during which children receive care may be less. For example, there are programs that provide care in two sessions, one in the morning and one in the afternoon. It is important to explain that the data reported in the table represents the program's total time of operation and does not take into account any possible organized activities or downtime during the school day.

Box 9. Selection systems

Sixty-six percent of programs in the region use some sort of instrument to allocate scarce slots to those who need them most. These instruments are usually created by the programs themselves, but they can be expensive to implement and they run the risk of being manipulated by those handling them in order to assign slots based on political or private interests.

On the other hand, some of the programs studied use national information and identification systems to focus their care. These systems are developed to support the eligibility processes of various social programs, and they are conceived with the idea of lowering the implementation costs associated with a different instrument for each program and reducing the possibility of manipulation by the authorities.

Such is the case of two programs in Colombia, the *Hogares Comunitarios de Bienestar* program and the *Buen Comienzo* program in Medellin, which use SISBEN (Beneficiary Selection System for Social Programs) to select the recipients of their services. This tool assigns a score of 1 (homeless and extremely poor) to 6 (high socioeconomic status) to households, depending on their consumption of durable goods, current income and household size. This information is collected in a socioeconomic file. If households fall within the first two levels, they are eligible to apply for these two programs.

Although from the point of view of each program that uses them, while the national targeting systems can facilitate processes, they also present problems. Camacho and Conover (2009) analyzed the manipulation of SISBEN in Colombia in 1997, when the algorithms used to calculate the score were made public. The authors find that manipulation is greater in municipalities with hotly contested elections, suggesting a possible modification for political ends. The National Planning Department of Colombia has worked to redefine SISBEN's methodology, and one of the objectives of this effort has been precisely to reduce the risk of manipulation of the system.

In Mexico, the Department of Social Development (SEDESOL) has implemented an instrument with 20 modules, called the Unique Socioeconomic Information Questionnaire, which tries to capture as much information as possible about housing, education, and employment status and the basic needs of a home.[14] This has proven to be a useful tool for the allocation of slots in several SEDESOL programs, including the *Estancias Infantiles* to support working mothers.

[14] Annex C - Unique Socioeconomic Information Questionnaire. SEDESOL. Available at: http://www.sedesol.gob.mx/work/models/SEDESOL/Resource/1818/1/images/AnexoC.pdf

Additionally, the programs function an average of 11 months per year, with an average of 5 weeks of break per year (not necessarily continuous). The average combination of 8 hours of care for 11 months suggests that the service probably generates disadvantages for mothers who work 40-hour-per-week shifts (and who need to travel from their place of work to the center where their children receive care). Similarly, the fact that centers close for more than a month each year requires that these families make alternative arrangements for the children's care during that period.

Of the programs surveyed, 61.8% reported that their centers have flexibility in their schedule, either by allowing early drop-off/late pick-up or through extended center hours when requested by families. Additionally, only 38.2% of the programs surveyed require compliance with a fixed schedule for all service providers. The analysis of these variables suggests that there is room to improve the flexibility of child care services to meet the needs of families with working fathers and mothers.

The lower panel of Table 12 summarizes information about the frequency of service of parenting programs. These programs, on average, operate 10 months a year. In some cases, they are intended as a parallel to the educational cycle, which

Table 11. Targeting instruments, by program type.

Child Care Services					Parenting				
Income	Geographic	Socio-economic data	None	Frequency	Income	Geographic	Socio-economic data	None	Frequency
		X		13			X		2
			X	5		X			1
	X	X		5		X	X		2
	X			3	X	X			1
X		X		3					
X	X	X		3					
X				1					
X	X			1					
			Total	**34**				**Total**	**6**

Source and preparation: the authors.

Box 10. Barriers to entry for child care services

A section of the interview carried out with programs focused on identifying what their directors think are the main barriers to entry faced by those households seeking to access their services. 80.6% of programs reported that their centers have a waiting list due to a lack of slots. In contrast, directors at two out of every 10 programs reported feeling that the demand for their services is less than the supply.

A second type of barrier to entry may be the location of the centers. When questioned about the location of child care services, three main factors (that are not mutually exclusive) were identified that determine where they are located. 65.7% of programs reported that the location of their centers is based on population density criteria. On the other hand, in 20% of cases the decision is made by the program's technical-zonal team, while in 31.4% of cases the decision is based on the demands of the communities themselves.

A third kind of barrier to entry has to do with the procedures and documents required for families who demand the service. 45.7% of programs interviewed identified the requirement of complying with the submission of registration documents for a child in the center. Among the more frequently required documents are the child's birth certificate and vaccination record (both in 77.1% of cases), a form from the center itself (74.3% of cases), the parents' identity cards (57.1% of cases), the child's health certificate (54.3% of cases) and a document that shows proof of residence (37.1% of cases).

A fourth type of barrier has to do with the program's ability to respond to the demand by families. 26.5% of programs acknowledged that they have inadequate staffing, and 64.7% admitted that they face funding constraints.

maintains an extended vacation period during each calendar year. Interactions (either individual or group) between beneficiaries and community workers occur an average of 1.2 times a week for 2 hours each meeting. 50% of these programs have a fixed duration, i.e., they consist of a learning cycle that begins and ends at specific times. On average, the duration of these cycles is two years. In some cases, the duration is determined by the age of the child, while in others, it is tied to the study of a specific curriculum.

3.6 Interventions of the model of care

In this paragraph and the three that follow, we analyze some characteristics of the early childhood development programs studied, which provide important information on structural variables associated with the quality of the services offered: comprehensiveness of the interventions provided, characteristics of their food and nutrition services, health and safety standards, and characteristics of the staff caring for the children.

This section focuses only on those programs that provide child care services, whether institutional or community-based. The purpose is to analyze the frequency with which the programs offer their beneficiaries eight possible types of interventions that usually constitute the model of care for these types of programs:

1- Child care services for children under 2 (often known as nursery school or daycare). These services may or may not have an educational component.

2- Child care services for children between the ages of 2 and 6 (kindergarten or preschool). Just like the previous case, these may or may not have an educational component.

3- Provision of food services. This includes the daily task of offering a meal or snack during the period of care. A program is defined as offering this service as long as the food given to the children is provided by the center (and not prepared at home).

4- Growth monitoring. This category

Box 11. Universal coverage programs

Most early childhood programs in the region are focused on serving the low-income population. However, some programs seek to provide universal care, meaning whoever requests the service must receive it. This is the case of preschool services in Jamaica, *Jardines Infantiles* in Argentina, and *Espacios de Desarrollo* in Rio de Janeiro.

Although these programs do not have an explicit target group, they make implicit decisions about whom to direct their service supply based on the location of their centers. In other words, the construction of new centers and the opening of preschools occur in areas where the needs are considered greatest. Furthermore, if there is excess demand relative to the number of spots available, these programs establish priority rules. For example, in the *Jardines Infantiles,* priority is given to children who live closest to the center, siblings of children who already attend the center, children of the center's staff, and children from disadvantaged families.

A program that aims to achieve universal coverage looks to create child care centers in medium- and high-income areas. The centers may also arise in spaces that allow for interaction between children of various socioeconomic backgrounds, who, in fragmented societies like those of Latin America and the Caribbean, would not otherwise have the opportunity to share a space. One example of this type of center was observed in Jamaica. We visited a preschool located in an affluent neighborhood of Kingston, which was attended by the children living in the neighborhood as well as the children of people who worked at the local businesses.

In Montevideo, one INAU preschool operates under unusual circumstances. Some years ago, a women's prison requested that the Ministry of Interior provide a center where inmates' children under 4 years of age could receive care and early stimulation. In 2007, the *Pájaros Pintados* center opened, attended by neighborhood children and the children of women in prison. Inmate mothers attend the first week of child care with their children in order to build confidence, and they periodically reduce the intensity of attendance. Although the differences between the two types of children are great and noted by the teachers through their games and attitudes, the parents living in the area have reacted in a very positive way to this initiative, which is based on a principle of integration.

refers to periodic efforts to do some kind of monitoring and follow-up on the development of the children's height and weight.

5- Nutritional supplementation. Provision of micronutrients or nutritional supplements at the center or their delivery to families so that they can be administered at home.

6- Health monitoring. Through referrals to a facility specialized in the provision of health services.

7- Direct provision of health services. In a few cases, the child care service goes a step further to guarantee the children's care, whether through agreements with nearby health centers or through permanent (or traveling) medical staff at the centers.

8- Work with parents by holding workshops that provide information on topics related to health, nutrition, parenting, stimulation and child development. These workshops are different from parent meetings or individual parent-teacher conferences to discuss the development of a particular child. What distinguishes them is an effort to provide educational support to the families of the children attending the center.

A ninth component that could be present in this list is whether the programs have a pedagogical model, around which they structure the activities and experiences of the children (and the adults with whom they interact) during the time period they attend the center. However, since this is a complex issue with many nuances, it is dealt with separately in the paper described in Box 3, which provides a comparative look at the learning guidelines of the programs studied. Box 12 summarizes the main findings of this study.

Table 13 contains a summary of the frequency with which each of the eight interventions described above are observed in programs offering child care services. It is worth noting that, on average, the programs visited offer their beneficiaries a combination of six of these eight types of interventions. The programs themselves allude to this range of activities when referring to their comprehensive nature. The variety of interventions described is important when considering the cost structure of a high quality child care service. At the same time, by incorporating issues related to education, health and nutrition, this table is illustrative of the intersectoral nature of child development. Therefore, to achieve financial and political sustainability, a strategy for delivering comprehensive child development services involves taking advantage of opportunities to connect and coordinate with other sectors and stakeholders.

The programs studied prioritize the care of children between the ages of 3 and 5 (all of the programs serve this group), while a smaller percentage (85.3%)

Table 12. Statistics on schedule and operating hours by program type.

	Obs.	Mean	Standard Dev.	Missing	Not Applicable
Child care services					
Months per year	33	11.2	1.00	0/34	1/34
Hours per day	34	8.31	2.47	0/34	1/34
Weeks of vacation per year	33	4.91	4.46	0/34	1/34
Flexibility in the schedule	34	61.8%	0.49	0/34	1/34
Operating hours established by the centers	34	38.2%	0.49	0/34	0/34
Parenting programs					
Months per year	6	10.5	1.76	0/6	0/6
Weeks per month	5	4.00	0.00	0/6	1/6
Meetings per week	5	1.20	0.45	0/6	1/6
No. of hours per meeting	5	2.00	1.00	0/6	1/6
Program with a fixed duration	6	50.0%	0.55	0/6	0/6
Duration of program in years	3	1.83	0.76	0/6	3/6

Obs. = Observations.
Source and preparation: the authors.

provides child care services for children 2 and under. This specialization makes practical and economic sense given that the care of children under two requires substantially greater resources, specifically a child-to-caregiver ratio lower than that needed to manage a group of older children. At the same time, it is likely that this figure is to some extent a reflection of the preferences of many homes in the region, where it is perceived that child care in the first years of life should take place in the family home. However, this data also reveals that the mothers of very young children who want to work or study have fewer options in terms of the public offering of child care services for their children during their first two years of life.

Table 13 illustrates that most of the programs studied (94.1%) include a feeding component, i.e., the center itself provides food to the children who attend it. In addition, about 85.3% of the programs visited monitor the growth of the children. However, only 52.9% of them complement this follow-up with the delivery of a nutritional supplement. 85.3% of the programs perform health check-ups on the children, particularly in an indirect manner, by referring parents to the respective services. 23.5% of programs offer health services on site (in the same facility where they provide child care services) or through agreements with nearby hospitals or health centers. Box 13 describes some examples of how these services operate in practice. Nine out of 10 programs complement child care with some type of workshop intended to inform and educate parents about issues related to parenting, nutrition, stimulation, health, or the care of their children. Box 13 also provides further details on these activities.

Table 14 supplements the information presented above with details about the frequency with which various combinations of the aforementioned eight *interventions* are observed. For example, in 10 of the 34 programs offering child care services, seven of the eight interventions are provided, i.e., all of them except direct health care. This appears to be the most common set of activities, or components of the care model, in the region. The next most frequent combination of services, observed in eight of the 34 programs, includes the same services described above, excluding the provision of micronutrients.

3.7 Food and nutrition

This section discusses in greater detail the food and nutrition interventions of programs that provide child care services. It was decided to examine the characteristics of these two components given that children from the poorest countries in Latin America and the Caribbean still face significant nutritional deficits. In addition, the window of opportunity to reverse this situation occurs precisely during the first two years of life, i.e., during a period in which this condition could have been identified in these children through their child care services.

The main indicators for food and nutrition are presented in Table 15, which covers all of the child care centers studied. In the discussion, reference is made to the differences found in these subjects among the subregions.[15] Table 15 is organized into panels. In the upper panel, some general characteristics of nutritional interventions are discussed. In the center

Table 13. Components of the programs that provide child care services.

Variable	Observations	Mean	Standard Dev.
Infant/toddler room (ages 0-2)	34	85.3%	0.4
Preschool/Pre-k (ages 3-5)	34	100.0%	0.0
Food	34	94.1%	0.2
Growth monitoring	34	85.3%	0.4
Nutritional supplements	34	52.9%	0.5
Health monitoring	34	85.3%	0.4
Direct health care	34	23.5%	0.4
Parent workshops	34	88.2%	0.3
Number of services	34	6.1	1.5

Source and preparation: the authors.

Table 14. Frequency of different combinations of child care service components.

List	Infant/ toddler room (ages 0-2)	Preschool/ Pre-k (ages 3-5)	Food	Growth monitoring	Nutritional supplements	Health monitoring	Direct health care	Parent workshops	Frequency
1	X	X	X	X	X	X		X	10
2	X	X	X	X		X		X	8
3	X	X	X	X	X	X	X	X	3
4	X	X	X	X		X	X	X	2
5	X	X	X	X	X	X	X		1
6	X	X	X	X	X	X			1
7	X	X	X	X	X			X	1
8	X	X	X	X			X	X	1
9	X	X	X		X	X		X	1
10	X	X						X	1
11		X	X	X	X	X	X	X	1
12		X	X	X		X			1
13		X	X			X		X	1
14		X						X	1
15		X							1
								Total	**34**

Source and preparation: the authors.

Box 12. The importance of early learning guidelines*

During visits to programs, curricular material was collected from those programs that had it and were able to share it with the authors. With this material, a team of researchers from Columbia University in the United States (Christine Harris-Van Keuren and Diana Rodríguez Gómez) conducted a comparative analysis of the early learning guidelines of 19 early childhood development programs in 13 countries in Latin America and the Caribbean. This study is available online at: http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=37374003.

The early learning guidelines describe what children should know or demonstrate as a result of their participation in a program. The exercise focused on guidelines for children 0 to 36 months old and employed a conceptual framework developed some years ago in the United States by Scott-Little et al. (2008). The following highlights some of the key lessons that resulted from this exercise.

Conceptualization and terminology: One of the highlights of this research was to document how different some programs turn out to be from others when it comes to conceptualizing early childhood development. These differences are reflected in the terms with which programs refer to the guidelines for early learning. We found concepts such as abilities, skills, expected learning, development, content and indicators. Such differences in terminology can complicate communication between stakeholders and make comparing similar concepts problematic.

Date of publication of the documents: The documents evaluated have publication dates between 1997 and 2011. While all the documents had been archived and were limited to describing the intentions of the curriculum writers, the older the document, the less relevant these past intentions appeared to be in relation to what actually happens in learning environments. From the beginning, there is a significant difference between the intentions of the curricula and their actual implementation, but the age of the document could widen this gap.

Modality: The programs studied in this research included three different types of educational environments. Some of them were developed to support parents in improving their skills in caring for their children, while others were created to provide daycare services, either in an institutional setting or in a more informal and community-oriented one. Programs that work with parents are different from those which are responsible for the care and nurturing of children and, therefore, one should be cautious with the comparisons to be made between them. In theory, the environment where a program is conducted should not affect the amount or type of early learning guidelines. However, it was noted that those guidelines did vary according to the modality. For example, in the socio-emotional, linguistic, cognitive, and physical and motor evaluation of early learning guidelines, this research reveals that parenting

programs, at least on paper, address fewer cognitive outcomes than child care services. The fact that the implementation process, training procedures, support materials and the time required for the details of the tasks (i.e., the intensity of the intervention) are also different depending on the modality of the program, suggests that it is precisely the children who require more aggressive interventions who might be receiving them on a smaller scale.

Age Structure: Some of curricula establish the age of the children in terms of years rather than months. The structure of the curriculum according to the child's age is important for many reasons. First, it can be confusing to stakeholders to determine whether early learning guidelines recommended for children 2 to 3 years of age are appropriate for children 24 to 36 months or 35 to 47 months. Second, large variations in the age structure could dismiss children with learning differences. Finally, it is important for the age structure to be clear as these programs are integrated with those designed for children over 36 months. This finding coincides with one from the U.S. study cited above.

Implementation: Lastly, early learning guidelines may well be clearly written, relevant and age specific, but in the end, they do not provide information about the daily events in the learning environment. These guidelines, like all other aspects of the curriculum, ultimately depend on two critical components: well-trained teachers and healthy children who are ready to learn. Without these components, the early learning guidelines are relegated to a paper existence.

* This box is based on an article written by Christine Harris-Van Keuren in July 2012 and published on IDB's blog *First Steps*: http://blogs.iadb.org/desarrolloinfantil_en/2013/03/13/new-publication-early-learning-guidelines-in-lac/

panel, details are provided about the food interventions offered by the programs. Lastly, the table's lower panel documents the frequency with which the programs provide specific nutritional supplements.

In examining each program's interventions in the previous section, it was documented that 94.1% of them provide food to children as part of their services. A much smaller percentage, only 52.9%, also provide nutritional supplements or micronutrients. 85.3% of the programs monitor the children's growth. By asking the directors to describe these efforts, it is discovered that this monitoring consists of recording height and weight, on average, every four-and-a-half months, or twice a year.

Although it would seem that food is a homogeneous component in almost all programs, by looking more closely, it is found that not all offer the same number of meals per day, nor at the same times. The most common meals are lunch and an afternoon snack. These two meals are present in 91.2% and 85.3% of the programs, respectively. Surprisingly, it is far less common to provide a meal in the morning. Breakfast and morning snack are provided by 67.6% of the programs. The absence of food in the morning is notable, as it is likely that this is the first meal of the day received by children from the most vulnerable households. Another striking fact is that 17.6% of the programs also offer dinner. The lower frequency of this practice is probably due to the fact that most centers close before the time most families commonly choose to have dinner. On average, programs reported that they look to provide about three quarters of the daily caloric intake required by children. However, not all of the programs had this information available, so it was a variable where information was missing in several cases. Just over 87.5% of the programs report having dedicated staff for food preparation tasks. This means that the responsibility for food preparation does not fall on the staff responsible for the care of children.

With regard to the provision of supplements and micronutrients, there are two common options. First, in 26.5% of the programs, the food cooked for the children includes fortified products. And second, at 17.6% of the centers, children receive micronutrients in the form of sprinkles (which are mixed with the food

[15] Tables with data disaggregated by subregion were not included to keep the report a reasonable length; however, they are available. Interested readers should contact the authors at mcaraujo@iadb.org or florencial@iadb.org.

offered by the center or given to parents to be administered at home). Additionally, 17.6% of programs reported the delivery of iron; 11.8%, vitamin A; 5.9%, folic acid; and 2.9%, zinc. In addition, one of every five programs provides children with deworming medicine with some frequency.

Interestingly, when comparing the practices of programs in the areas of food and nutrition among the subregions of the continent, some differences stand out. First, all of the programs in the Southern Cone and Andean regions provide food, and 84.6% of the programs in Central America do so. Second, half of the centers in the Southern Cone also provide nutritional supplements, while in the Andes and Central America this occurs in almost 60% of the centers. Third, all of the programs in the Andean region, 9 out of 10 in the Southern Cone and 8 out of 10 in Central America monitor the growth of children. Fourth, with regard to food, all of the Southern Cone programs consistently report serving two main meals per day (breakfast and lunch) plus an afternoon snack, and half of the centers offer dinner. While breakfast is less common in the Andes (42.9% of the centers) and Central America (61.5%), a snack is provided at every Andean program and in more than half of the Central American centers. This is noteworthy because it is in these subregions that target child care services at underprivileged populations, where it is likely that children will arrive at daycare in the morning without having eaten at home beforehand. Fifth, in regard to micronutrients and supplements, different approaches are observed between the subregions. For example, programs in the Southern Cone and Central America use fortified foods and, less frequently, take charge of delivering iron or micronutrient sprinkles. In contrast, in the Andes, the delivery of micronutrient sprinkles is the most common, followed by iron, vitamin A, and the use of fortified foods. Exclusively in the Andes and Central America, one third of the programs also administer deworming medicine to the children.

Box 13. Some examples of how to conduct parent workshops and how direct health care works

88% of child care programs at centers provide some sort of workshop for parents, while 26% have a component of direct health care. But what do these components mean and what do they look like in practice within the broad context of the countries in the region?

Models of intervention with families

Work with parents is performed in various manners. In Medellin, the *Buen Comienzo* program provides care beginning at pregnancy. This involves working with the mother at breastfeeding and stimulation workshops beginning in the third trimester of pregnancy and then working with her on a monthly basis on issues of childcare and best practices for parenting, health and nutrition. In Panama, the *Instituto Panameño de Habilitación Especial* (IPHE) serves children with special needs. An important part of their work is to help families understand the psychological and social impact that raising children can have on them. With this goal in mind, a range of activities is offered (including workshops, individual meetings, film discussions, dramatizations and retreats). The topics most frequently addressed are the parents' acceptance of their children's condition, how to manage the children at home, the role and responsibility of the family, behavioral aspects, and health issues.

Direct health care

Direct health care is rare in the region's public child care services. Although 85.3% of the programs refer sick children to a hospital or talk with parents about how to comply with check-ups, only 23.5% take additional measures. For example, in Rio de Janeiro and in some parts of Jamaica, programs look to build new child care facilities in proximity to health centers, and they negotiate agreements with these institutions to give priority to children served by the programs. At the *Guarderías de la Seguridad Social* in Mexico, one of the most important components of their care is an on-site nurse's office with trained staff and frequent visits by doctors to the centers. In Costa Rica, CEN-CINAI provides direct care to children through an interdisciplinary team consisting of doctors, physical therapists and audiologists, who identify problems and follow up with cases as needed.

3.8 Health and safety

The main topic of this section, health and sanitation standards, is closely related to the quality of child care services for very young children. Hand-in-hand with quality food and nutrition services, programs that provide care to children under 3 must focus on compliance with very strict protocols for safety, health, and hygiene. These protocols include actions that form part of the daily routines of child care (e.g., hand washing). They also include standards related to the quality of the materials used in the construction of the spaces and the furnishings with which the children come into contact. Lastly, they also refer to the guidelines that caregivers must follow when extraordinary circumstances such as accidents arise or children fall ill.

During the first years of life, children's immune systems are being strengthened. Attendance in a group care setting (such as a daycare center) carries with it a greater risk that children will be exposed to viral diseases and infections. All of the efforts made by centers to feed and monitor the nutritional status of the children will yield better results in so far as they can minimize the occurrence of disease among the children attending these centers.

Similarly, the most recent medical evidence documents that children are particularly vulnerable to certain types of contamination during early childhood (e.g., the presence of lead or asbestos). Thus, it is essential to ensure optimum safety conditions that minimize children's contact with toxic substances during the school day at the centers.

Table 16 details some information on the frequency with which the programs visited meet some of these requirements. For example, the table documents that although 91.2% of the programs require that each child care center have a specific play area for children, in practice, only 78.3% have one.

With regard to health and safety standards, when they exist, information is available about who performs the follow-up and inspections and whether this is an internal or external entity. Inspections by a third party from outside the program are probably more objective. While 78.1% of the health inspections (and 75% of

Table 15. Statistics on the food and nutrition services of child care services.

	Obs.	Mean	Standard Dev.	Missing	Not Applicable
Nutrition					
Provide nutritional supplements	34	52.9%	0.51	0/34	0/34
Monitor growth	34	85.3%	0.36	0/34	0/34
Frequency of monitoring (months)	29	4.52	2.86	0/34	5/34
Provide food	34	94.1%	0.24	0/34	0/34
Breakfast	34	67.6%	0.47	0/34	0/34
Morning snack	34	67.6%	0.47	0/34	0/34
Lunch	34	91.2%	0.29	0/34	0/34
Afternoon snack	34	85.3%	0.36	0/34	0/34
Dinner	34	17.6%	0.39	0/34	0/34
Dedicated food services staff	32	87.5%	0.34	0/34	2/34
Percentage of calories needed daily	19	77.4%	0.17	4/34	11/34
Nutritional supplements					
Micronutrient powders (Sprinkles)	34	17.6%	0.39	0/34	0/34
Vitamin A	34	11.8%	0.33	0/34	0/34
Zinc	34	2.9%	0.17	0/34	0/34
Iron	34	17.6%	0.39	0/34	0/34
Folic acid	34	5.9%	0.24	0/34	0/34
Deworming medication	34	17.6%	0.39	0/34	0/34
Fortified Foods	34	26.5%	0.45	0/34	0/34

Obs. = Observations.
Source and preparation: the authors.

safety inspections) are the responsibility of an internal body, just under half of the programs have inspections performed by an external entity (only 44%).

3.9 Human capital

This section provides a detailed analysis of the characteristics of the staff responsible for the care of children in the programs. Many of the key variables that describe the quality of child development services are associated with the characteristics of the staff members and the incentives they receive in their work. A few are mentioned here. First, the child-to-caregiver ratio, or the number of children each adult is in charge of, is a structural variable that is closely associated with the ability of caregivers to provide children with quality experiences through warm, sensitive, and individualized interactions. Second, the education level of the caregivers and, more specifically, their training in key skills necessary for working with children provides them with better tools to stimulate learning and adequately address the needs of the children. Third, the salary received by staff members who care for children is an important stimulus that motivates them to perform their work, but it also attracts talented people to the industry and helps to retain good professionals, once they have gained experience.

Throughout this section, we seek to distinguish between three staff profiles: teachers (usually with higher-level training), teacher aides, and caregivers or community workers. In most programs that provide child care services through the institutional modality, the staff in charge of caring for children is a combination of at least two of these three profile types (for example, teachers supported by teacher assistants or community workers). Conversely, in programs that provide child care services through a community-based modality, it is common for the majority of program staff to have the profile of a caregiver (community workers or mother caregivers).

Table 17 presents a summary of the educational requirements demanded of the staff at different programs offering child care services. This table shows that most programs have full secondary education as a minimum requirement for the three staff profiles. 75.9% of the programs require tertiary (higher) education of their teachers, while only 41.2% and 30.4% demand this level of education of their caretakers and teacher assistants, respectively. The same trend is observed for the specialization in early childhood education; it is required for 62.5% of teachers, 30.4% of teacher assistants and 41.2% of caregivers.

Table 18 compares different combinations of profiles for hired staff at the two types of programs—child care services and parenting. It is clear that in parenting programs, teachers are, in relative terms, a more abundant resource; three of six parenting programs hire only teachers, while none of the child care services hires teachers *exclusively*. In fact, the most common hiring situations at child care services are the combination of teachers

Table 16. Health and safety standards of child care services.

	Obs.	Mean	Standard Dev.	Missing	Not Applicable
Play					
Centers that must have play areas	34	91.2%	0.29	0/34	0/34
% of centers with play areas	31	78.2%	0.27	0/34	3/34
Health					
Inspection by an internal body	32	78.1%	0.42	2/34	0/34
Inspection by an external body	32	43.8%	0.50	2/34	0/34
% of centers that meet standards	26	91.6%	0.17	0/34	8/34
Safety					
Inspection by an internal body	32	75.0%	0.44	2/34	0/34
Inspection by an external body	32	43.8%	0.50	2/34	0/34
% of centers that meet standards	26	87.1%	0.24	0/34	8/34

Obs. = Observations.
Source and preparation: the authors.

Table 17. Educational requirements for teachers, teacher aide and caregivers in child care services.

	Observations	Mean	Standard Dev.
Teachers			
High School Education	32/32*	87.5%	0.34
Post-secondary Education	32/32	75.0%	0.44
Specialization in Early Childhood Education	32/32	62.5%	0.49
Teacher Aides			
High School Education	23/23	60.9%	0.50
Post-secondary Education	23/23	30.4%	0.47
Specialization in Early Childhood Education	23/23	30.4%	0.47
Caregivers			
High School Education	17/17	70.6%	0.47
Post-secondary Education	17/17	41.2%	0.51
Specialization in Early Childhood Education	17/17	41.2%	0.51

*Information is available for all 32 of the programs that hire teachers. In addition, complete information can be found on teacher aides and caregivers.

Note: Since each program has different job titles for the staff in charge of caring for children, the tables that analyze the programs in an aggregate manner group together the different titles under the categories "teachers," "teacher aides" and "caregivers" for comparison purposes. Thus, teachers, directors, supervisors, and center managers fall under the category "teachers." Facilitators, teacher assistants, aides, and others are included in the category "teacher aides." Lastly, some job titles included in the category "caregivers" are aides, community mothers, educational assistants, stimulation specialists, educational coordinators, food educators, and social educators. It is worth noting that these distinctions were made according to the specifics of each program, and given the variety of job titles, some staff positions are categorized differently depending on the program. For example, educators at Fundación Integra are considered teacher aides, while at the program PAN-Manitos, educators pertain to the category "teachers."

with teacher aides (in 13 of 34 programs), followed by the combination of the three staff profile types (in 11 of 34 programs).

Although programs demand certain educational requirements of their staff, in reality the actual education levels of the personnel working at these services differs. Table 19 presents the actual average educational levels exhibited by the staff serving children at programs that provide child care services in the region. This table shows that staff education levels are basic. For instance, teachers, on average, have completed 2.6 years of post-secondary higher education. Teacher assistants, on average, have barely finished high school. Meanwhile, caregivers, on average, have 10 full years of education, that is, they have not even finished high school.

One way to strengthen the abilities of staff with low levels of education is through constant supervision, mentoring, and training efforts. Table 19 documents that the number of days per year allocated by child care services for staff training is also low (between 11 and 14 days).

Table 19 also shows that child care duties at most child care services fall on caregivers (and not on teachers or teacher aides). To give an idea of the magnitude, for each teacher employed by these programs, there are almost 10 caregivers

Table 18. Type of staff employed, by program type.

Child care services				Parenting			
Teachers	Teacher Aides	Aides/ caregivers	Frequency	Teachers	Teacher Aides	Aides/ caregivers	Frequency
X	X		13	X			3
X	X	X	11	X		X	1
X		X	5	X	X		1
X			4	X	X		1
		X	1				
		Total	**34**			**Total**	**6**

Source and preparation: the authors.

Table 19. Characteristics of child care service staff.

	Obs.	Mean	Standard Dev.	Missing	Not Applicable
Teachers					
Number of teachers in 2011	29	1,531.2	2,152.8	3/34	2/34
Years of education	28	14.6	2.08	4/34	2/34
Training days per year	28	13.8	10.5	4/34	2/34
% of programs with teachers	34	94.1%	0.24	0/34	0/34
Teacher Aides					
Number of teacher aides in 2011	17	4,183.4	9,010.6	6/34	11/34
Years of education	19	12.9	2.92	4/34	11/34
Training days per year	20	11.3	9.46	3/34	11/34
% of programs with teacher aides	34	67.6%	0.46	0/34	0/34
Caregivers					
Number of caregivers in 2011	16	12,058.1	25,801.3	1/34	17/34
Years of education	15	10.7	4.06	2/34	17/34
Training days per year	15	13.1	9.30	2/34	17/34
% of programs with caregivers	34	50.0%	0.51	0/34	0/34

Obs. = Observations.
Source and preparation: the authors.

and three teacher aides (aggregate data, not by program).

Table 20 reports the average child-to-caregiver ratios, or the number of children per adult, in the programs that provide child care services. On average, child-to-adult ratios for each age group are double the standards set by the American Academy of Pediatrics and the American Public Health Association (see Table 21). Furthermore, a lot of variability is noted in this ratio. For example, in the care of children ages 0 to 1, there are programs with two children per caregiver and others with 20, in other words, seven times more than the standard three children per caregiver recommended by the American Academy of Pediatrics.

Table 22 describes the staff who operate parenting programs. We must acknowledge that, unfortunately, even with a small sample of just six parenting programs in the study, there is a lot of missing data. Even with this limitation,

Table 20. Child-to-caregiver ratios for child care services, by age group.

Age range	Observations	Mean	Standard Dev.	Missing	Not Applicable
0-1 years	29	6.16	3.79	0/34	5/34
1-2 years	30	6.61	3.37	0/34	4/34
2-4 years	32	10.3	4.95	0/34	2/34
4-6 years	26	14.3	8.65	0/34	8/34

Source and preparation: the authors.

Table 21. Child-to-caregiver ratios for child care services, recommended by the American Academy of Pediatrics and the American Public Health Association.

Age range	Child-to-caregiver Ratio	Maximum Group Size
0-12 months	3	6
13-30 months	4	8
31-35 months	5	10
3 years	7	14
4 and 5 years	8	16

Source: American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. Caring for Our Children: National Health and Safety Performance Standards; Guidelines for early care and education programs. 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics, Washington, DC: American Public Health Association. Available at: http://nrckids.org

in this type of program, teachers are, in relative terms, a more abundant resource. In aggregate terms, for each teacher there are nearly 1.3 teacher assistants. The number of years of education for teachers is comparable to those providing child care services (two years beyond secondary) but significantly fewer for teacher aides (just eight).

The number of training days for teachers is similar between parenting programs and child care services. However, training for teacher aides is four times more frequent as compared to training for aides at child care services.

Regarding parenting programs, Table 23 documents that there is less variability among child-to-caregiver ratios (number of children per caregiver) between age groups; these ratios are just slightly lower for the age 0 to 2 group than for the two older groups. This means that, on average, the programs do not allow for greater frequency or intensity of care for the youngest children.

It is worth noting that the child-to-caregiver ratios for each age group are much higher than those of child care services, in part because, even when the meetings occur on an individual basis (a community worker and a family), this is a service which is provided less frequently, allowing one person to visit several homes in a week. In addition, some of the programs studied provide their services through group meetings (Argentina, Mexico, and Ecuador for older children), which allows a single facilitator to reach more families. Since this service differs in nature from a child care service, the child-to-caregiver ratios for parenting programs should not be evaluated according to the standards of Table 21.

The indicators in the above tables were also analyzed in a disaggregated manner, in order to compare trends between different subregions.[16] This comparison proves interesting for programs that provide child care services, since there are enough observations in the sample to observe differences. The elements that stand out are summarized below.

First, education levels for the three staff profiles (but particularly for teachers and teacher aides) are better in the Southern Cone than in any other subregion. Teachers, teacher aides and caregivers in the Southern Cone have 16, 14 and 11 years of education on average, respectively. This equates to one more year of education than Andean teachers and two more than Central American ones; five more years of education than Andean

Table 22. Characteristics of parenting program staff.

	Obs.	Mean	Standard Dev.	Missing	Not Applicable
Maestros					
Number of teachers in 2011	6	5,479.3	10,621.9	0/6	0/6
Years of education	3	14.3	1.15	3/7	0/6
Training days per year	5	15.0	20.1	1/7	0/6
% of programs with teachers	6	100.0%	0.00	0/6	0/6
Maestros asistentes					
Number of teacher aides in 2011	2	4,358.5	6,135.6	0/6	4/6
Years of education	2	8.00	2.83	0/6	4/6
Training days per year	2	44.5	50.2	0/6	4/6
% of programs with teacher aides	6	33.3%	0.52	0/6	0/6
Cuidadores					
Number of caregivers in 2011	0	N/A	N/A	1/6	5/6
Years of education	0	N/A	N/A	1/6	5/6
Training days per year	0	N/A	N/A	1/6	5/6
% of programs with caregivers	6	16.7%	0.41	0/6	0/6

Obs. = Observations.
Source and preparation: the authors.

[16] Although not included in order to keep the report a reasonable length, these tables are available to interested readers (mcaraujo@iadb.org or florencial@iadb.org).

Table 23. Child-to-caregiver ratios for parenting programs, by age group.

Age range	Observations	Mean	Standard Dev.	Missing	Not Applicable
0-1 years	6	15.6	9.23	0/6	0/6
1-2 years	6	16.0	8.80	0/6	0/6
2-4 years	6	16.1	8.60	0/6	0/6
4-6 years	4	16.5	9.30	0/6	2/6

Source and preparation: the authors.

teacher aides and two more than Central American ones; and 1.5 more years of education for caregivers in the Southern Cone than in the other two subregions.

Second, the frequency of training days per year is lower in the Southern Cone than in the other subregions. This trend may reveal an effort to compensate for the differences in staff training that were described above. Staff members in the Andean and Central American subregions have an average of 12 to 15 days of training per year, while staff in the Southern Cone is trained from 10 to 12 days per year.

Finally, it is interesting to compare the child-to-caregiver ratios. The Southern Cone comes close to the care standards recommended by the American Academy of Pediatrics for infants and toddlers (4.8 children per caregiver in the 0 to 1 age group, when the recommendation is three, and six children in the 1 to 2 age group, when the ideal is four or five). In contrast, in the Andes and Central America, the child-to-caregiver ratio is 7 in the 0 to 2 age group. However, there is a clear break in this distinct Southern Cone trend when we observe the ratios for children over 2. Above that age group, the three subregions have ratios higher than those recommended by the American Academy of Pediatrics. Specifically, ratios of 11 children per caregiver are observed for the ages 2 to 4 group (10 in Central America) when the recommendation is seven, and 13 children for the ages 4 to 6 group (15 in Central America), when eight are recommended. There is no explanation for this change in the trend in the Southern Cone. This could have several causes including greater demand for these services for older children accompanied by an insufficient supply of professionals. Or it may simply be the result of public policy decisions regarding the prioritization of improvements in child-to-caregiver ratios for the most vulnerable group—infants.

3.10 Track record of the programs in recent years

This section examines recent developments to programs in terms of their size. It contrasts an important observation. While programs that provide child care services show a tendency to grow in coverage, number of facilities, and personnel, parenting programs appear to experience the opposite trend. It is worth noting that these variables, particularly those that reference data from three to five years ago, contain a large number of missing values. This is because the programs themselves do not have this information systematized. Despite intense follow-up to visits in order to retrieve information that may not have been available during the interview, it appears that this type of data is not often documented in the programs' records since it was difficult to retrieve it from a large number of programs. For example, only 18 of 35 child care service programs had data about their coverage five years ago.

Table 24 examines this data for the child care services. In the last five years, coverage of child care services grew by 116.9%, while the number of centers increased just 59% and staff 60.5%. In other words, the trend has been towards an expansion in the number of children served by each provider and also by each teacher or caregiver. Still, it is encouraging that, on average, the staff growth rate exceeds the number of children who attend the program for the year prior to the study and for the preceding three. This shows a recent effort to reduce the child-to-caregiver ratios that could have grown too large due to the expansion in coverage. Hopefully, this trend will continue and accelerate in the future. However, it goes without saying that behind these averages there is a great deal of heterogeneity.

Table 24. Track record of child care services over the last five years.

	Observations	Mean	Standard Dev.
Coverage			
Last year's coverage	34	89,818	210,249
Last year's growth rate	29	3.2%	0.13
3-year growth rate	27	19.3%	0.55
5-year growth rate	18	116.9%	3.32
Number of centers			
Last year's number of centers	34	3,350	12,453
Last year's growth rate	29	2.8%	0.09
3-year growth rate	27	38.4%	1.04
5-year growth rate	15	59.0%	1.46
Staff			
Last year's staff	32	11,828	28,820
Last year's growth rate	22	16.3%	0.36
3-year growth rate	16	51.0%	0.87
5-year growth rate	12	60.5%	0.75

Source and preparation: the authors.

Table 25 presents similar data for the parenting programs. There are only a few observations. However, the latest trend (from the last year) of this type of program reflects cutbacks, both in coverage and personnel. Interestingly, in terms of magnitude, cuts in staff and coverage are similar to the year before the study. This could be interpreted as evidence that the programs have not changed their care modality (for example, they have not moved from an individual care model to a group one, nor have they modified their child-to-caregiver ratios) but instead they have reduced the scale of their operation.

3.11 Institutionality

The institutions that child care services and parenting programs depend on have varying nuances. In this section, however, we wish to describe some basic features related to the "location" of these programs in the spectrum of social sectors and levels of government.

Of the 40 programs included in the study, 15 (37.5%) directly depend on an institution specialized in children's issues. This type of institution (such as the Institute for Children and Families [INFA] in Ecuador or the Colombian Family Welfare Institute [ICBF]) may be an independent entity or it may depend, in turn, on some ministry (in Ecuador's case, INFA is part of the Ministry of Economic and Social Inclusion). Thirteen other programs are part of a national or local government ministry other than the Ministry of Education. 7 of the programs depend on secretariats or ministries of education at the national or local level. The remaining programs directly depend on the local government (three cases), or they are independent entities (two cases).

Table 25. Track record of parenting programs over the last five years.

	Observations	Mean	Standard Dev.
Coverage			
Last year's coverage	6	207,991	228,660
Last year's growth rate	6	-16.8%	0.33
3-year growth rate	6	0.36%	0.79
5-year growth rate	3	24.6%	1.03
Staff			
Last year's staff	6	7,750	12,305
Last year's growth rate	5	-17.5%	0.32
3-year growth rate	5	-0.82%	0.74
5-year growth rate	2	-20.7%	0.36

Source and preparation: the authors.

Box 14. The Caribbean and its progress in regulation and legislation

Caribbean countries have made dramatic efforts to increase the coverage and quality of their preschool services for children ages 3 to 5. They have also been innovative in promoting the participation of private sector partnerships (churches, schools, civil society) in service delivery (see Box 16 on Trinidad and Tobago). However, what probably best characterizes the Caribbean is the advances in sector regulation and legislation, something which in many countries of the region is just getting underway.

The case of Jamaica's legislation is the most illustrative (http://www.ecc.gov.jm/legislation.htm). The Early Childhood Commission under the Ministry of Education has 35 inspectors and five senior inspectors who are responsible for supervising 2,700 early childhood education institutions (only 131 of them public). With regard to their professional qualifications, inspectors must have at least one degree in early childhood education (and senior inspectors, two). There are also 70 officials and development supervisors who monitor centers monthly through observation visits and training sessions for teachers. They monitor quality standards in the following 12 dimensions:

1 - Staff
2 - Programs
3 - Behavior and interaction/relationship with children
4 - Physical environment
5 - Equipment and furnishings
6 - Health
7 - Nutrition
8 - Safety
9 - Children's rights and protection and equity
10 - Interaction with parents and community members
11 - Administration
12 - Finance

After this monitoring, inspectors produce a report that they share with the center and publish on the Commission's website (http://www.ecc.gov.jm/ecc/ECIReports/). In this process, some lessons have been learned. First, it remains a challenge to have sufficient funds to carry out the monitoring and development program (for example, mobilization, training costs, etc.). Second, the registration process of the centers is difficult and there are delays in receiving documents or certificates that must be issued by the police and fire departments because they themselves do not have enough staff or budget to visit the centers and verify compliance with the minimum conditions.

One way to analyze the institutionality of the programs is to look at how integrated they are with other national stakeholders related to early childhood. Box 15 describes in greater depth two recent initiatives being implemented in Colombia and Nicaragua to formulate an institutional framework that promotes intersectoral coordination.

There is a particular issue related to intersectoral coordination that is discussed in the following paragraph. Even when programs do not directly depend on the education sector, one would expect them to have institutional links with this sector, particularly with regard to the teaching model utilized by its services. An interesting fact that was obtained from this research is concerned with the development of the curricula used by the programs studied. Forty programs reported having a curriculum. However, 22 of these curricula were independently developed by the programs themselves. The remaining 18 programs reported using curricula developed by the Ministry of Education for preschool education. A cross-comparison of the institutional affiliation of the programs against the type of curriculum used does not reflect major differences between those programs that depend on child institutes, ministries or the Ministry of Education itself. In other words, there is not just a lack of coordination with the education sector (represented by the Ministries of Education) but rather an overall lack of coordination among the programs involved in child development.

Another way to analyze the institutionality of the programs is from the point-of-view of how they organize their operation.

One model that has been adopted in several countries involves subsidizing third parties (community organizations, local governments, foundations, or individuals) to be service providers. The subsidies for service operation are proportional to the number of children served. Besides the public subsidy, the funding of these centers is complemented with a fee charged to parents who use the service. Some programs offer an additional subsidy to the provider in order to upgrade or furnish the facilities where the center will operate. Several of the programs visited operate under this scheme, including *Hogares Comunitarios de Bienestar* in Colombia, *Centros Infantiles del Buen Vivir* in Ecuador, the Jamaican preschools, and *Estancias Infantiles* in Mexico. Under this operating structure, the program has an administrative role and it oversees compliance with the quality standards that must be met by their providers. In practice, there is significant variability in terms of the programs' ability to monitor compliance with these standards and to ensure that children receive consistent, high quality services at the different facilities that they subsidize.

3.12 Costs

One of the most difficult parts of the interview to complete during the program visits, and later required a great deal of

Box 15. Intersectoral models and initiatives in Colombia and Nicaragua

Nicaragua

In late 2011, Nicaragua adopted the National Policy on Early Childhood (PNPI) as a guiding instrument for its sectoral and intersectoral initiatives aimed at children under 6 years of age, their families and communities. Under this framework, each social sector institution, according to its mandate and expertise, is responsible for providing resources and implementing actions to improve comprehensive child development indicators.

As part of its implementation, the PNPI stipulates that sector entities link themselves to the National Social Welfare System (SNBS). The Executive Organization Act grants the Ministry of Family power to function as the entity responsible for the protection of vulnerable groups, while the Ministry of Health is responsible for governance and care in nutrition and health, and the Ministry of Education is responsible for supply and governance beginning at the first level of preschool. The importance of this policy framework is that it recognizes the need to invest in protecting the country's human capital through intersectoral actions that match the human life cycle.

The challenge will be to implement this policy while taking into account the need to expand coverage, better focus on the most vulnerable population, and promote the quality of services.

Colombia

In recent years, Colombia has made progress in developing its early childhood strategy *"De Cero a Siempre."* This strategy seeks for the planning of actions directed towards children in early childhood to be done in a coordinated fashion between the different levels of government and between the sectors responsible for the provision of services, in order to ensure comprehensive care for children.

The strategy has defined a path for early childhood care, which identifies specific actions that must occur at every stage, beginning at pregnancy, so that children can reach certain achievements or accomplishments as outlined by the strategy. The care path links the services that help families and communities to be able to promote the development of children in that stage. Furthermore, the strategy defines conceptual and operational criteria that must guide early childhood care and establishes standards of quality.

The implementation of the strategy was entrusted to the Intersectoral Commission for Comprehensive Early Childhood Care, which was created for this purpose. The Commission is formed by the Office of the President, the Administrative Department of the President, the Ministry of National Education, the Colombian Family Welfare Institute, the Ministry of Health and Social Protection, the Ministry of Culture, the National Planning Department and the Administrative Department of Social Prosperity. The commission is located within the Office of the President's High Council for Special Programs.

follow-up effort, was the collection of financial information about the programs' income and expenditures, the wages they pay their employees, and the fees charged to the families who use their services. The annual cost per child was estimated based on this information. The estimate was prepared using each program's income, and in cases where this information was unavailable, annual expenditure figures were used. In spite of the difficulties, it was possible to collect cost information for 28 of the 34 child care services and four of the six parenting programs. The reference year for cost information was the year before the interview (2010). Although we attempted to collect this information for previous years, in order to understand the evolution of these variables over time, we had little success in obtaining a full set of data. To compare financial information between programs and countries, all monetary values were converted to U.S. dollars. Due to the variability of the exchange rate in some of the countries in the region, the average exchange rate from December 2010 was used for the conversion of all currencies and for all years in which financial information was available. Still, the comparison of cost information between different services is complex. Recent articles by Levin and Schwartz (2012) and Myers et al. (2012) discuss some of the methodological difficulties in measuring these costs.

Table 26 and Table 27 summarize the principal financial information for child care services and parenting programs, respectively. On average, the annual cost per child borne by child care services is US$1,239.9. However, this variable fluctuates within a fairly wide range. In fact, the most expensive program reports values of US$3,264 per year, per child. The cheapest earmarks just US$26 per year, per child. It is important to clarify that this variable does not include operating costs of the program that are covered by fees paid by parents. At least 26.5% of child care services visited expect operators to supplement the public funding they receive with parental contributions. There are other programs that prohibit the collection of these fees in their rules, but in practice they acknowledge that this is a frequent occurrence in their centers. This is the case, for example, at the *Centros Infantiles del Buen Vivir* in Ecuador.

Although we attempted to define recent developments in terms of operating costs for this type of program, we collected information for just 14 of the 28 child care facilities that provided data on their costs. At these services, the resources intended to cover the costs per child increased 8.6% in the year before the study, i.e., between 2009 and 2010. In a previous table, it was reported that for the same period, coverage of child care services expanded by 3.2%, which means that, on average, the public resources earmarked for the funding of centers grew faster than the number of children who attend.

Box 16. Models of partnership with civil society: The case of Trinidad and Tobago and SERVOL

Early Childhood Care and Education centers (ECCEs) in Trinidad and Tobago fall under the auspices of the Ministry of Education. Today, there are 107 public centers and 72 in association with SERVOL (Service Volunteered for ALL). In 1974, SERVOL, a nonprofit volunteer organization, became a provider for the Ministry of Education with 50 centers under its care. The organization took responsibility for these centers until 2005.

Since 1987, the Government of Trinidad and Tobago, through the Ministry of Education, has given SERVOL a subsidy to pay the salaries of the ECCE teachers and instructors. While public funds cover salaries, the innovative aspect is that since its involvement, SERVOL has had to find the funds each year for infrastructure, maintenance, utility bills and taxes. In 2005, the Ministry once again assumed responsibility for the operation of the centers, but funding is still channeled through SERVOL as operator.

This structure has worked very well in practice. What is probably behind the success of this partnership is the constant monitoring of service quality standards, with a process similar to Jamaica's (see Box 14).

With regard to information on staff salaries at child care centers, the first observation is that the staff working at them only has an employment relationship with the program (or the facility where they work) at 82.4% of the programs visited. Therefore, at 27.6% of the programs, the staff responsible for children's care work as volunteers—work for which they may or may not receive a modest stipend—without an employment relationship with the facility where they work or the program to which it belongs.

is consistent with the previously reported decrease in coverage of parenting programs in the same period, of about 16%. It is worth noting that this data should be interpreted with caution since only three programs provided information about the change in costs over the last year.

Finally, data on the salaries of parenting program staff suggests that only 16.7% of staff members have an employment relationship with the program in charge of

Table 26. Annual cost per child and staff salaries for child care services.

Variable	Observations	Mean	Standard Dev.
Annual cost per child in 2010 (dollars)	28	1,239.9	1,044.0
Increase in cost per child in the last year	14	8.6%	0.44
Parents pay for the services	34	26.5%	0.45
Staff who have an employment relationship with the program	34	82.4%	0.39
Average teacher salary (dollars)	32	578.8	380.6
Average teacher aide salary (dollars)	21	486.7	331.5
Average caregiver salary (dollars)	16	446.5	277.5

Source and preparation: the authors.

On average, programs that provide child care and hire qualified teachers pay these employees a salary of US$578.8 per month. A teacher aide's salary is about 84% of this value, while that of caregivers is 77%. Teachers' salaries range between US$70 and US$1,421 per month, teacher aides' pay falls between US$54 and US$1,065, and caregivers make between US$10 and US$989 per month. International evidence suggests that the salaries of child care service staff predict the quality of these services better than any other variable at the center level (Kagan, 2010). The variability documented in this variable speaks to the wide disparity in the quality of these services in the region. We will further explore this issue later in this section.

There is little information about the costs associated with parenting programs. Only three of the six respondents provided data. The average annual cost per child is US$247.2, and it fluctuates between US$13 and US$599. None of the six programs interviewed charge a fee to parents who participate in the service, which means that these values represent the total operating costs of the programs. With regard to the cost trajectory, on average, costs decreased 6.3%. This figure

working with families. In fact, it appears that the rule for this care modality is to work on a volunteer basis. However, in those programs where teachers are hired, the wages paid are, on average, lower than those of all the staff profiles working at child care services, at US$241.90 per month (42% of the salary earned by a teacher at a child care service). Teacher aides for parenting programs earn a salary corresponding to 16% of that of a teacher. It is likely that such large wage discrepancies have to do with the fact that parenting programs, unlike child care services, do not offer full-time care. They can also be related to the higher frequency of parenting programs in rural areas, where wage levels are probably lower.

In this last part of the section that explores program costs, we wish to compare how they relate to other predictive variables of service quality. Due to the greater availability of information, this analysis focuses exclusively on child care services.

Figure 5 illustrates the relationship between program operating costs and the interventions that constitute their care model, or the number of services they offer (this issue is further analyzed in

Table 27. Annual cost per child and staff salaries for parenting programs.

Variable	Observations	Mean	Standard Dev.
Annual cost per child in 2010 (dollars)	4	247.2	265.2
Increase in cost per child in the last year	3	-6.30%	0.38
Parents pay for the services	6	0.0%	N/A
Staff who have an employment relationship with the program	6	16.7%	0.41
Average teacher salary (dollars)	3	241.9	154.4
Average teacher aide salary (dollars)	2	39.1	8.8

Source and preparation: the authors.

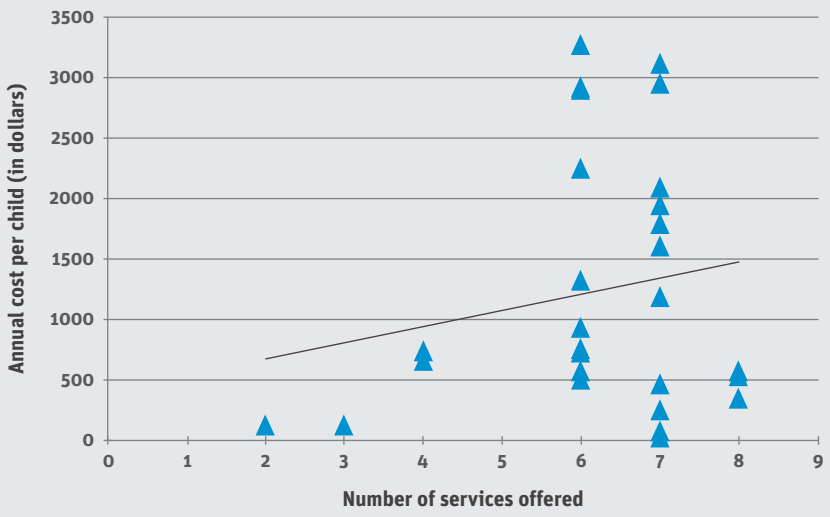
section 3.6). As expected, there is a direct proportional relationship between the two variables: the programs that offer more services or those that seek to provide comprehensive care, cost more.

Figure 6 describes the association between unit costs and the size of program coverage (in logs). Here the relationship between the two variables is inverse. As coverage increases, the unit cost of care decreases. This diagram is consistent with the presence of certain economies of scale in service operation.

In Figure 7, the correlation between the unit cost of child care services and the minimum education requirement demanded of the more highly trained staff in each program (measured in years of education) is explored. As expected, those programs that have higher standards and require their staff to have completed higher levels of education are more expensive because they must offer attractive salaries to draw staff with this profile to their facilities.

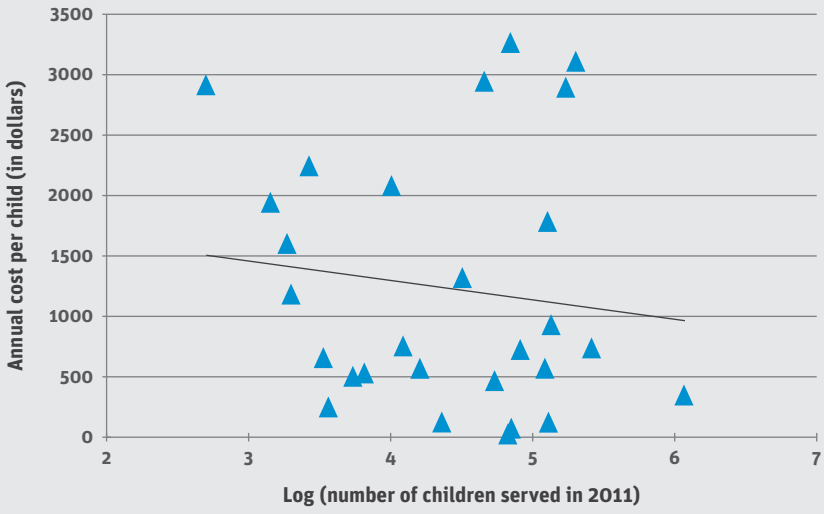
Figures 8, 9, 10 and 11 describe the association between child care service costs and the child-to-caregiver ratio (or the maximum number of children per adult allowed for each age group) that they maintain. These ratios are described separately by age group (in four intervals: 0 to 12 months, 13 to 24 months, 25 to 48 months and 49 to 60 months). Child-to-caregiver ratios are structural variables closely associated with the quality of care received by children. This should not be surprising given that, in contexts where an adult is in charge of caring for large groups of small children, it is difficult to provide responsive, individualized care with quality interactions to each child. As expected, the costs of child care services are negatively related to child-to-caregiver ratios: the lower the ratios, the higher

Figura 5. Costs and components of child care services.



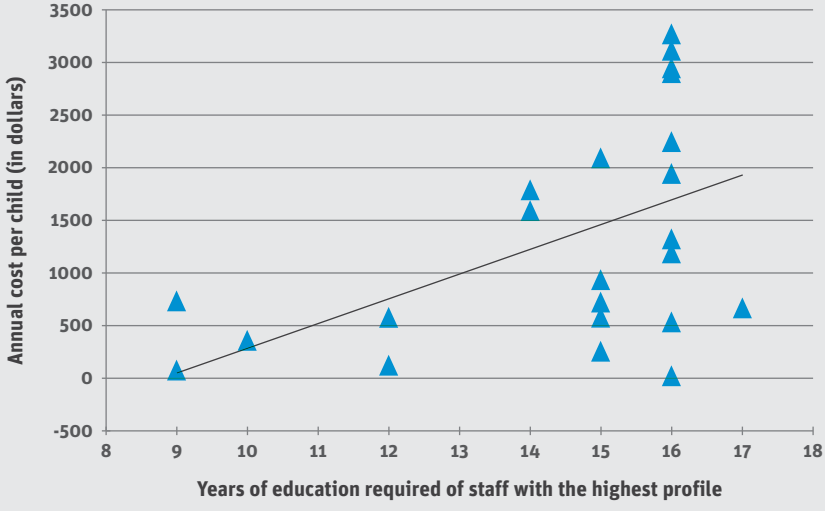
Source and preparation: the authors.

Figura 6. Costs and coverage of child care services.



Source and preparation: the authors.

Figura 7. Costs and minimum staff education requirements.



Source and preparation: the authors.

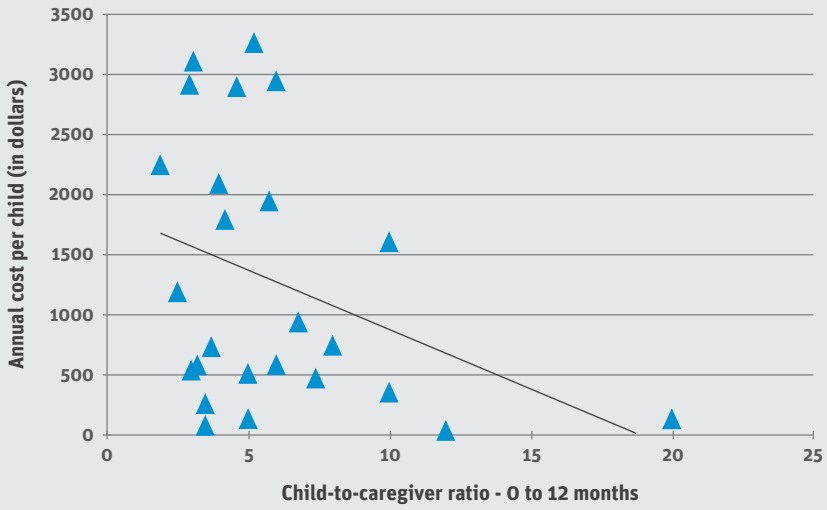
the costs. In other words, guaranteeing quality child care services during early childhood requires low child-to-caregiver ratios, which, inevitably, is expensive. Figure 10 is the notable exception, where costs do not show a clear trend. Two observations (corresponding to the Uruguayan programs *Programa de Primera Infancia* and *Programa Nuestros Niños* both of the city of Montevideo, and both with a high cost per child) give this graph a positive slope but less steep that the rest of the figures in this section.

3.13 Results of the observation of child care service operations

As described at the beginning of Section 2.3., the interviews with the program directors were complemented with visits to a few of the facilities where the programs provide their services. Those visits (one to three facilities per program) were planned in advance and organized by the directors interviewed. Thus, the selection of places to visit

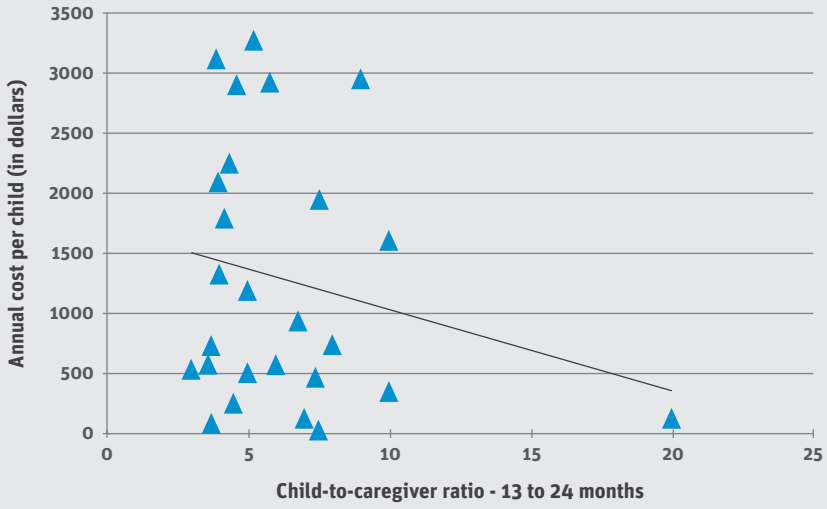
is likely to have been biased in order to share with the authors—outside visitors—those experiences that stand out for their positive results. The visits lasted a couple of hours during which we sought to observe very specific aspects of the centers' operation. All of these observations were coded in a form designed specifically for this purpose.[17] We humbly recognize all of the limitations that an exercise of this nature may present. Still, it seems important to report the main elements that drew our attention when systematizing the data from these observations. It is possible that the most important point of this section is to document that there is still a lot of work ahead in order to ensure that the quality standards stipulated by the programs and their directors are translated into

Figura 8. Costs and child-to-caregiver ratios (0 to 12 months).



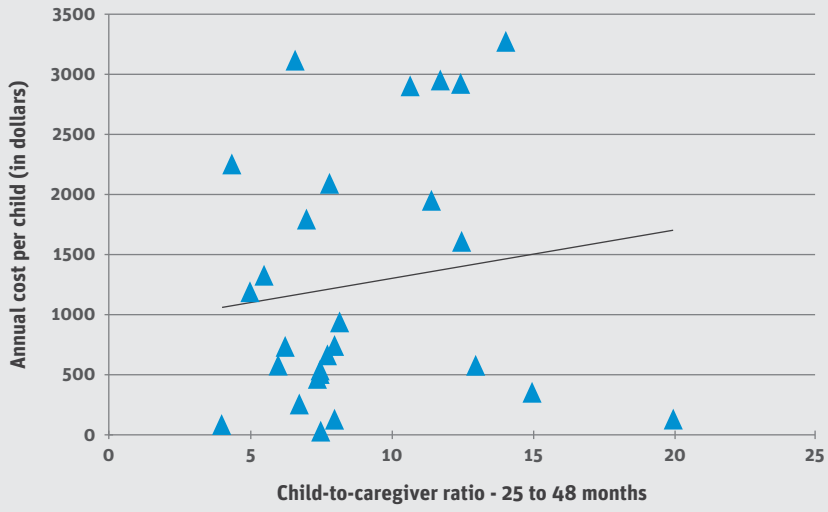
Source and preparation: the authors.

Figura 9. Costs and child-to-caregiver ratios (13 to 24 months).



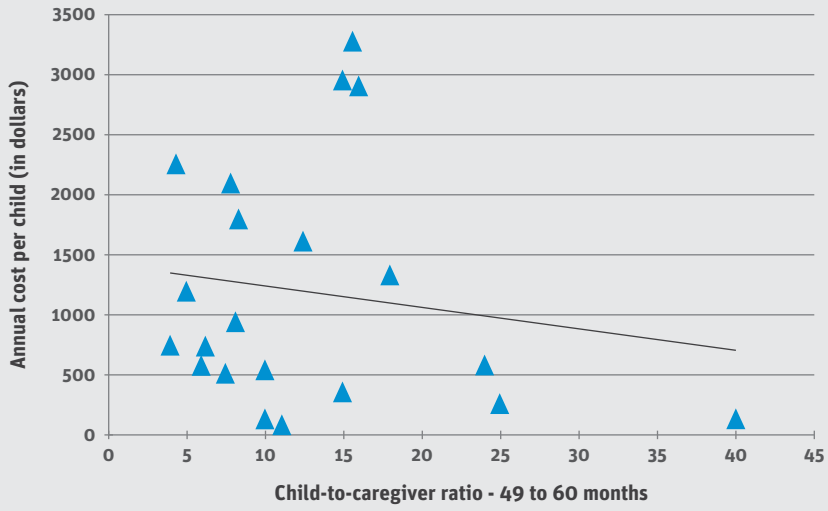
Source and preparation: the authors.

Figura 10. Costs and child-to-caregiver ratios (25 to 48 months).



Source and preparation: the authors.

Figura 11. Costs and child-to-caregiver ratios (49 to 60 months).



Source and preparation: the authors.

the daily practices of the operators of these services. This section focuses on programs that provide child care services because, due to their location in urban or marginal urban areas, it was feasible to perform a greater number of observations at such programs. In total, we were able to observe 58 child care facilities and just six parenting programs. The dimensions observed at the child care services were general characteristics, the state of the infrastructure and the environment around the center, bathrooms and kitchens, materials and equipment, and interactions between children and adults.

General Characteristics

At the 58 centers that were visited, it was found that there were, on average, nearly

[17] Available at http://www.iadb.org/SocialProtection

130 children per center. This figure is higher than the average size reported by the program directors. It could be that, for accessibility reasons, the few centers that were visited were the largest in terms of the number of children due to their presence in urban areas with high population density. However, at those 58 facilities, we identified, on average, five teachers and eight teacher aides or caregivers, i.e., more children and fewer adults than those reported by program directors. Overall, this represents a child-to-caregiver ratio of 10 children per adult and could suggest that programs face difficulty in maintaining the child-to-caregiver ratios dictated by their standards.

The centers visited had an average of five small rooms, where children were organized by age. In speaking with the staff at the facilities, it was identified that in 55% of cases, parents pay a fee for the services they receive from the centers. The variability in the amount of this fee is high, but it averages US$19 per month (it fluctuates in a range between US$2). It is worth noting that in interviews with directors, only 26.5% had reported that families are required to pay a monthly fee for their services. With regard to the child care services' hours of operation, those visited reported that they operate an average of five days a week, nine hours a day. Most programs operate five days a week and a few are open a sixth day. However, greater heterogeneity is observed in the daily schedule, since the centers operate between four and 15 hours per day. The latter case is that of *Programa Nacional Abrazo*, which opens at 7 am and stays open until 10 pm.

Infrastructure and environment

With regard to the environmental conditions found around the center, the following elements were identified. First, in terms of accessibility, 83% of the 58 facilities visited have a street that leads directly to the place where the center is located and, on average, they lie just one block from a place where families can access public transportation. Only 10% of the facilities are in places with excessive noise. With regard to hygiene and cleanliness, 17% of the facilities visited had animals around the center, 9% had waste and trash, and 10% standing water.

With respect to outdoor spaces, most of the facilities visited (88%) had a place for outdoor activities and 72% had some kind of play equipment. Upon observing the interior spaces, it was found that only two thirds of the facilities had rooms with adequate ventilation and 88% of them had natural light. Just over 90% of the rooms appeared to have enough space. However, only 72% of the centers visited reported that they meet the fire safety regulations established by the program to which they belong.

Bathrooms and Kitchens

When examining the condition of the bathrooms used by the children and the kitchens where the food they consume is prepared, it was verified that 91% of the facilities visited had water service and, in almost all cases, they were connected to the city's drinking water supply. However, despite having water service installed, the quality leaves a lot to be desired given that 30% of the facilities experience constant water outages.

Children were observed washing their hands at 87% of the facilities visited. This, in spite of the fact that only 63% of the centers have sinks proportional to the size of the children who use them. In about 15% of the places visited, there were not enough sinks for the number of children in attendance. Disinfecting products for the bathroom toilets were found in almost 90% of the facilities visited. In addition, all of the toilets had a supply of toilet paper. However, at one quarter of the centers visited, the size of the toilets is not proportional to the size of the children, and some 20% of centers admit that the amount of toilets is insufficient given the number of children who attend the service.

In terms of the cleanliness of the bathrooms, it was found that 90% were in good condition. Only 7% of centers reported having problems with damaged pipes. In addition, two-thirds of the bathrooms had trash cans with a lid. The presence of exclusive diaper-changing areas for the youngest children was also observed in about 84% of the facilities visited. However, the use of latex gloves during diaper changes is not a common practice, as it is performed in only 15% of the centers observed.

Of the 58 centers visited, 91% had a kitchen area. Of those with a kitchen, 96% had a refrigerator. However, only 49% had an exhaust fan in the kitchen area. In 94% of the facilities, it was verified that the kitchen is a restricted access area for children due to safety reasons.

Materials and equipment

With regard to this topic, we observed different elements related to the availability of materials and the organization of the rooms where the children spend most of the day. One positive point is that only in a very small number of facilities (3.5%) rooms are organized as classrooms. In contrast, the vast majority (98%) have furniture appropriate to the size of the children, toys that stimulate motor development (88%), and role-playing games (75%).

One out of every two rooms is decorated with artwork made by the children, although in one-third of the rooms, the decoration is not hung at the children's level but instead at that of the adults. Children's books were observed in the rooms at 95% of the centers visited, and 93% had materials for painting. 26% of the centers reported having access to computers. Furthermore, 23% of the centers had rooms that were decorated with plants, and 11% even had a pet (i.e., an animal whose care was part of the children's activities and learning). In almost all of the facilities visited (95%), the use of available materials for learning and play was verified.

Interactions between children and adults

Lastly, during the visits to the centers, we took care to observe the type of interactions that occurred among children and adults. It was verified that group activities took place at 90% of the centers visited, and 73% had individual activities. At 79% of the centers, we witnessed how the children's teachers or caregivers encouraged their participation in the activities being carried out. Just as often, we found children asking questions or making comments related to the day's tasks.

Similarly, part of the observation protocol required that attention be paid to situations in which teachers or caregivers reacted to instances of positive or negative behavior from any of the children in their care. In 73% of cases, when a child exhibited good behavior, it was possible to witness how the teacher or caregiver used this occasion as an opportunity to encourage this type of behavior. However, in 31% of the centers visited, it was possible to observe situations where, in the face of negative behavior on the part of the child, the adult in charge reacted in a reproachful, indifferent or even careless manner.

3.14 Conclusions from the comparative analysis

The sections in this chapter present abundant descriptive evidence on the major child care services and parenting programs in 19 countries in Latin America and the Caribbean. This section briefly summarizes some of the elements that stand out in this comparative analysis.

The region exhibits tremendous heterogeneity in terms of child development programs. This is manifested in many dimensions. In terms of coverage, large-scale programs coexist with many small initiatives. As for the modality of care, there is a community-based supply and an institutional one. Even within the same type of service, as in the case of child care services, the benefits package or components that programs offer their beneficiaries vary. There are enourmous differences in the budgets in the budgets that these programs have available to them and—directly related to the issue of funding—in the quality parameters that can be achieved. Therefore, as an example, the differences in regard to educational profile and compensation for the staff responsible for the care of children stand out between the programs studied.

The most common modality of care in urban areas is child care services, which may be provided in institutional or community settings. In several countries, we are seeing a movement away from the community modality toward the institutional modality for these types of services. This process is part of the major effort to improve the quality of care provided to children. Child care services constitute the modality of care with the greatest coverage in the region.

In contrast, parenting programs that work with families, whether on an individual or group basis, predominate in rural areas. Operating within this modality has its own challenges. Their ability to be effective depends on the quality of interaction that develops between families and the program staff providing the services. This involves investing major effort to train and supervise program staff and develop program content, ensuring that it is culturally relevant. Given the dispersion of families in rural areas, this modality may require significant and costly logistical efforts, both for the program and for the families themselves if they need to travel in order to participate.

The supply and demand for child care services (primarily urban) have grown in recent years, while programs offering parenting services (primarily rural) have seen a decline in coverage. International evidence illustrates that the returns on investment in child development are greater when efforts are focused on the most vulnerable groups. The region has focused most of its resources and efforts on marginalized urban populations, presumably because the majority of working women are concentrated in those areas. There remains the challenge of scaling programs to rural areas, where the highest rates of poverty are concentrated.

Child development programs seek to take a comprehensive approach. However, more work can be done to intensify this approach. This involves recognizing the importance of programs that address needs in education, health and nutrition. It is essential for child development programs to have a teaching model and properly trained staff to implement it.

Child development programs may be one of the first points of contact with the government for families with young children. This link can be used to ensure that children have access to these programs and that their families can be referred to another public service to which they are entitled. The financial and political sustainability of a strategy for delivering comprehensive child development services involves taking advantage of opportunities to connect and coordinate with other sectors and stakeholders.

Given the enormous challenge that nutritional issues continue to present in the region, through child development programs, greater efforts can be made to ensure timely and adequate nutritional support for the children participating in these services. This entails not only a review of programs' food guidelines but also the possibility of monitoring children's proper growth and distributing nutritional supplements through these programs. Additionally, it involves educating program staff and families about the importance of mealtime as an opportunity to develop warm and responsive interactions between adults and children.

In the region, there is still a long way to go in terms of defining, monitoring, and meeting quality standards on the part of providers responsible for the operation of centers providing child development services. These processes are essential, both in cases where the provision of publicly funded services depends on third parties and in those where the program itself is in charge. In addition, most countries do not have an institutional framework in place that can monitor the quality of the supply from the private sector. The issue of monitoring is of particular importance given that many countries have recently expanded the coverage of these services by subcontracting them to third parties.

Generally speaking, the care and attention of children in early childhood programs in the region fall to shorthanded, poorly-paid staff with little training. There must be investment to ensure attractive compensation and ongoing training programs that allow for the hiring and retention of a skilled workforce in this sector.

Guaranteeing quality child care during early childhood requires low child-to-caregiver ratios, which, inevitably, is expensive. Programs offering more services or those seeking to provide comprehensive care cost more. The average annual cost per child varies greatly among the different programs in the region. On average, the cost stands at US$1,239.9 for child care services and US$247.2 for parenting programs. Without a significant budget commitment,

it is impossible to think about real improvement in the quality of these services in the region.

Providing quality child development services does not offer much in the way of political gain or votes in the short term. However, it is an investment with high returns. Therefore, political will is essential in order to contemplate reforms that guarantee access to quality services for children in Latin America and the Caribbean.

4

4. Experiences of countries and individual programs

Chapter 4 consists of a country-by-country description of the child development services interviewed as part of this study. The information is organized in a consistent manner to facilitate the description of the data and the comparison between programs and countries. Four tables were developed for each country in order to draw a distinction between the main features of the programs while attempting to maintain consistency with the definitions and topics covered in the comparative analysis presented in Chapter 3.

1- The first table provides an overview of the programs, including coverage size, age group served, number of employees, number of centers, hours of operation, geographical area in which they operate, description of the target population, and targeting method.

2- The second table contains financial information for 2010 from the programs that had it available. The table shows the programs' revenues and expenses, along with major expenditure categories. In many cases, the programs classify their expenses under different categories, which makes it difficult to produce a homogeneous categorization. Additionally, some programs do not have exact information about disaggregated expenses, because they function through bids and concessions with third parties who independently allocate these expenses. Despite these limitations, with the available data, the table reports the annual cost per child in 2010 and a description of the centers' policy regarding parental copayments (not included in the total revenues of any program).[18]

3- The third table describes how the programs' main services are provided in the areas of care, nutrition, monitoring of development, and work with parents from the centers.

4- The last table summarizes program standards and regulations, along with corresponding information about staff profiles, child-to-caregiver ratios, and wages.

An additional aim of this section is to describe the unique characteristics that define some of the programs in the region and to highlight those aspects that are not reflected in the systematized data.

Before entering into the country-by-country analysis, Table 28 shows the set of structural variables that the specialized literature suggests best represent the quality of a child care service, which are: the number of years of education of the teachers, teacher aides and caregivers; their wages, expressed in US$ per month in 2010; and the number of children under the responsibility of each teacher/caregiver (i.e., the child-to-caregiver ratio). In general terms, there is a positive correlation between years of education and wages, as well as a negative correlation between child-to-caregiver ratios and wages (with the exception of teacher aides).

Similarly, this confirms the trends from the previous section showing that certain countries (the Southern Cone, Costa Rica and Mexico) have programs that employ teachers/caregivers with more years of education, pay higher wages, and operate with lower child-to-caregiver ratios. For teachers in particular, the highest salary offered is that of the *Fundación Integra* program in Chile, with US$1,420.8, and the lowest salaries from PEI-CONAFE in Mexico, *PAN-Manitos* in Bolivia, CEDIF in Peru and PAININ in Nicaragua with less than US$100 per month.

[18] For those countries that lacked sufficient data to complete the second table, available financial data was added to the first.

Child-to-caregiver ratios are less than six children per caregiver for the age 0 to 2 group at child care programs in the Southern Cone (except *Jardines de Villa Paranacito*), Costa Rica, Colombia (*Un Buen Comienzo*), the Dominican Republic (*Estancias Infantiles and Programa de Primera Infancia*), El Salvador, Mexico (IMSS), Nicaragua, and Paraguay.

Table 28. Structural variables associated with quality, by program.

Country	Program	Teachers		Teacher Aides		Caregivers		Child-to-caregiver ratio				Annual cost per child (US$)
		Education	Salary (U.S.$)	Education	Salary (U.S.$)	Education	Salary (U.S.$)	0 a 1	1 a 2	2 a 4	4 a 6	
Section A: Child Care Services												
Argentina	Centros de Protección Infantil	16	754.8	13	654.2	N/A	N/A	2.5	5.0	5.0	5.0	1,184.8
Argentina	Jardines de Infantes Ciudad de Buenos Aires	16	1,068.4	12	1,006.5	N/A	N/A	6.0	6.5	11.8	15.0	2,946.4
Argentina	Jardines Infantiles de Villa Paranacito	16	629.0	16	629.0	N/A	N/A	6.0	9.0	23.5	30.0	N/A
Bolivia	Desnutrición Cero	N/A	959.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1,179.0
Bolivia	Pan-Manitos	N/A	107.0	N/A	N/A	N/A	N/A	6.0	5.0	15.0	20.0	N/A
Brazil	Atención en Educación Infantil Fortaleza	16	885.3	N/A	N/A	12	368.9	N/A	4.0	5.5	18.0	1,317.7
Brazil	Espacio de Desarrollo Infantil - Rio de Janeiro	14	826.2	N/A	N/A	13	469.8	4.2	4.2	7.0	8.3	1,783.5
Brazil	Proyecto de Primera Infancia de Sobral	13	826.2	N/A	N/A	13	826.2	2.5	3.8	8.8	10.0	N/A
Chile	Fundación Integra	16	1,420.8	16	1,064.6	14	688.8	5.2	5.2	14.1	15.6	3,263.8
Chile	JUNJI	16	865.1	13	622.4	N/A	N/A	4.6	4.6	10.7	16.0	2,895.0
Colombia	Buen Comienzo	15	652.6	N/A	N/A	N/A	261.0	3.7	3.7	6.2	6.2	725.0
Colombia	Hogares Comunitarios de Bienestar	N/A	N/A	N/A	N/A	10	146.2	10.0	10.0	15.0	15.0	353.7
Colombia	Secretaría de Integración Social	14	759.1	12	621.3	N/A	N/A	8.3	8.3	13.0	16.7	N/A
Costa Rica	CEN-CINAI	15	618.0	13	N/A	N/A	N/A	3.2	3.6	13.0	24.0	574.8
Ecuador	CIBV	15	220.0	7	200.0	N/A	N/A	6.8	6.8	8.2	8.2	935.5
El Salvador	Modelo de Atención Integral	N/A	402.0	N/A	68.6	N/A	N/A	5.0	5.0	7.5	7.5	504.1
Guatemala	Hogares Comunitarios	12	275.8	6	175.5	N/A	175.5	6.0	6.0	6.0	6.0	574.1
Guatemala	Programa de Atención Integral a la Niñez	12	470.1	N/A	N/A	N/A	N/A	20.0	20.0	20.0	40.0	128.6
Honduras	Bienestar Familiar y Desarrollo Comunitario	14	398.9	N/A	N/A	6	335.1	10.0	10.0	12.5	12.5	1,602.8
Honduras	PAIN	16	957.4	12	478.7	6	N/A	7.7	7.7	N/A	N/A	N/A
Jamaica	Early Childhood Commission	12	187.5	14	N/A	N/A	N/A	5.0	7.0	8.0	10.0	126.3
Mexico	Guarderías de la Seguridad Social	16	304.2	16	190.1	11	190.1	3.8	5.1	11.0	N/A	3,104.2
Mexico	Estancias Infantiles para Madres Trabajadoras	9	325.2	N/A	184.4	N/A	N/A	8.0	8.0	8.0	4.0	737.4
Nicaragua	PAININ	9	70.0	N/A	N/A	6	10.0	3.5	3.7	4.0	11.1	76.7
Panama	Centros de Orientación Infantil y Familiar	15	N/A	12	N/A	N/A	N/A	3.5	4.5	6.8	25.0	257.1
Panama	Programa de Estimulación Precoz	16	560.0	N/A	400.0	16	700.0	12.0	7.5	7.5	N/A	25.9*
Paraguay	Abrazo	16	419.7	17	644.8	2	386.9	1.9	4.4	4.4	4.4	2,241.4
Peru	CEDIF	N/A	99.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	753.9
Peru	Programa Nacional Wawa Wasi	N/A	106.6	N/A	85.3	N/A	N/A	7.4	7.4	7.4	N/A	467.6
Dominican Republic	Espacios de Esperanza	15	321.7	10	53.6	N/A	N/A	N/A	N/A	22.0	22.0	N/A

Country	Program	Teachers		Teacher Aides		Caregivers		Child-to-caregiver ratio				Annual cost per child (US$)
		Education	Salary (U.S. $)	Education	Salary (U.S. $)	Education	Salary (U.S. $)	0 a 1	1 a 2	2 a 4	4 a 6	
Section A: Child Care Services												
Dominican Republic	Estancias Infantiles de la Seguridad Social	16	185.0	14	123.3	N/A	N/A	3.0	3.0	7.5	10.0	530.8
Dominican Republic	Programa de Primera Infancia	15	369.9	13	281.5	15	308.3	3.9	3.9	7.5	7.5	2,091.0
Trinidad and Tobago	Early Childhood Care and Education Centers	17	1,415.8	14	786.6	11	550.6	N/A	N/A	7.7	N/A	662.3
Uruguay	Plan CAIF	16	832.0	11	702.0	N/A	N/A	9.2	9.2	10.9	10.9	N/A
Uruguay	Programa de Primera Infancia del INAU	16	844.0	15	867.7	11	738.6	5.4	9.7	17.6	N/A	2,910.4
Uruguay	Programa Nuestros Niños	16	1,301.6	15	860.2	15	988.5	5.4	7.0	10.2	N/A	1,941.3
Section B: Parenting Programs												
Argentina	Primeros Años	15	N/A	10	45.3	N/A	N/A	22.7	22.7	22.7	N/A	13.0
Bolivia	Kallpa Wawa	15	285.3	6	32.8	N/A	N/A	9.1	9.1	9.1	9.1	N/A
Chile	CASH	N/A	N/A	N/A	N/A	N/A	N/A	15.0	15.0	15.0	15.0	598.7
Ecuador	CNH	13	370.0	N/A	N/A	N/A	N/A	12.0	12.0	12.0	12.0	302.1
Jamaica	Rovings Caregivers	N/A	N/A	N/A	N/A	N/A	N/A	5.0	7.0	8.0	N/A	N/A
Mexico	Programa de Educación Inicial - Conafe	N/A	70.5	N/A	N/A	N/A	N/A	30.0	30.0	30.0	30.0	75.0

*This value includes care at health centers, which significantly lowers the cost.
Note: The average number of years of education and salary are reported.
Source and preparation: the authors.

4.1 Argentina

Much of the public provision of early childhood services in the Southern Cone occurs through municipal programs, due to the strong movement toward decentralization found in the countries of this subregion since 1985. This is the case for three out of the four early childhood programs included in the study for Argentina: three municipal child care services and one national parenting program. Table 29 shows the main features of these programs.

Centros de Protección Infantil - CPI (under the Directorate-General for the Strengthening of Civil Society, Ministry of Social Development of the City of Buenos Aires) are child care services operating in the city of Buenos Aires. They were created in 2009 as a model that attempts to build on areas that the preschools under the Ministry of Education in each province do not address: working directly with parents, a community approach, and a care component. In 2011, the program served 2,007 children under 5 in 21 centers, and it was expected to have a total of 30 centers by 2012. The target population is low-income families in economically vulnerable situations, and the program targets its care by examining family income, the geographic location of the centers, and a vulnerability index.

In turn, the Ministry of Education of the City of Buenos Aires manages the city's *Jardines Infantiles*. Although the first preschools appeared in the late 19th century, joint administration of these schools began in 1940. Later, in 1978, as a result of decentralization processes, preschools across the country came to be administered by the municipalities. The preschools serve 46,818 children in the city of Buenos Aires through 206 centers. Coverage is universal, above and beyond enrollment priorities related to the integration of the family group, vulnerability, and proximity to the preschool. Special priority is given to: a) children living near the center, b) siblings of children who already attend the center, or c) the children of school employees. Also, and even more importantly, precedence is given to children living in substandard housing, to those who

come from single-parent homes, to those whose parents work in the area, and those with unmet basic needs. This method of prioritization results in a very heterogeneous population at the preschools. The preschools function only 10 months a year, with sessions lasting 6.5 hours a day.

Similar to the City of Buenos Aires, the Ministry of Education of the Province of Entre Rios manages the *Jardines Infantiles del municipio de Villa Paranacito*. In recent years, the Program has seen a tremendous expansion of coverage, and it is currently working with 43,949 children in 1,172 preschools in the province. The preschools have a six-hour day, and they only operate nine months of the year. They offer universal coverage, and only working mothers receive priority for slots.

The *Programa Nacional Primeros Años* of the National Council for Social Policy Coordination (formed by the Ministries of Education, Health and Social Development) is a parenting program with national coverage. Created in 2006, it attempts to reach families who are not served by preschools or early childhood care centers. The program covers 434,850 families with children under 4, in conditions of vulnerability. The program operates in 214 locales, 47 of which are rural. Slots are targeted using the vulnerability index of the National Office of the Information, Monitoring and Evaluation System for Social Programs (SIEMPRO) and the program AHÍ, which help define populations in conditions of vulnerability or with difficult access to government services.

Table 29. Overview of major public child development programs visited in Argentina.

Institution	Directorate-General for the Strengthening of Civil Society, Ministry of Social Development of the City of Buenos Aires	Ministry of Education of the City of Buenos Aires	Ministry of Education of the Province of Entre Rios, Municipality of Villa Paranacito	National Council for Social Policy Coordination (MINEDU, MINSAL and MDS)
Program	**Centros de Protección Infantil**	**Jardines de Infantes Ciudad de Buenos Aires**	**Jardines Infantiles Villa Paranacito**	**Programa Nacional Primeros Años**
Children served (2011)	2,007	46,818	43,949 (2010)*	434,850
Age group served	0 to 60 months	0 to 72 months	0 to 72 months	0 to 48 months
Centers in operation (2011)	21	206	1,172 (2010)*	N/A
Staff (2011)	346	3,855 (2010)	2,802 (2010)*	8,697
Operating schedule	12 months per year 5 days per week 8 hours per day	10 months per year 5 days per week 6.5 hours per day	9 months per year 5 days per week 6 hours per day	12 months per year 1 session per month, frequency may be lower
Geographic coverage	Local coverage - Buenos Aires	Local coverage - Buenos Aires	Local coverage - Entre Rios	214 locales/47 rural
Target population	- Low-income population - High social vulnerability	- Families with unmet basic needs - Living near the school	- Universal	- Vulnerable families
Targeting method	Targeting by income, geographic location and a vulnerability index	Geographic targeting, and priority is given to siblings who have previously attended the center	Priority is given to working mothers	Targeting by SIEMPRO and Programa AHÍ vulnerability index. Priority is given to areas with high levels of isolation (inaccessibility) and difficulties accessing health and education.

* The number of centers corresponds to the province of Entre Rios, since information could not be obtained about Villa Paranacito. Villa Paranacito is a city of 3,800 inhabitants, while the province of Entre Rios has 1.2 million inhabitants.
Source and preparation: the authors.

With regard to financial aspects, Table 30 shows that of the four programs, the only one that charges parents a co-pay is the *Centros de Protección Infantil*, with a value of US$29.3 per month. At US$3.5 million, the CPIs have the lowest budget of all of the programs reviewed, where wages account for the greatest expense (57%), followed by infrastructure costs (21%). The CPIs have an annual cost per child of US$1,184.8 *Jardines Infantiles* of Buenos Aires operates on an annual budget of US$151.2 million, with staff salaries constituting the main expense (77%) and a cost of US$2,946.4 per child per year. Lastly, *Programa Nacional Primeros Años* spends US$3.9 million a year, once again with significant spending on salaries (68%), followed by training costs (17%). The cost per child is very low for the type of care provided, due to the low frequency (monthly) of intervention and the use of unpaid interns in the role of facilitators (US$13 per child per year). Financial information for *Jardines Infantiles de la ciudad de Villa Paranacito* is unavailable.

With regard to how the programs provide their services, Table 31 shows that the CPIs separate the children by age group. They supply breakfast, lunch and snacks, and there is no monitoring protocol for the children's nutritional development. *Jardines Infantiles de Buenos Aires* and *Jardines Infantiles de Villa Paranacito* are very similar in terms of their care components since they both follow national guidelines issued by the Ministry of Education. Both programs separate the children by ages, employ professional teachers, and provide breakfast, lunch, a snack, and—if the center offers an evening session—dinner. The children's anthropometric measurements are taken at health centers via referral.

Working with parents is not a strong suit for Argentina's child care services, although the CPIs distinguish themselves in that regard as compared with the *Jardines Infantiles*. The CPIs develop workshops with child development

Table 30. Income and expenditures of major public child development programs visited in Argentina.

Institution	Directorate-General for the Strengthening of Civil Society, Ministry of Social Development of the City of Buenos Aires	Ministry of Education of the City of Buenos Aires	Ministry of Education of the Province of Entre Rios, Municipality of Villa Paranacito	National Council for Social Policy Coordination (MINEDU, MINSAL and MDS)
Program	**Centros de Protección Infantil**	**Jardines de Infantes Ciudad de Buenos Aires**	**Jardines Infantiles Villa Paranacito**	**Programa Nacional Primeros Años**
Total expenditures (2010)	US$3,547,752.6	US$151,217,777.2	N/A	US$3,899,152.7
Administrative expenses	0.0%	9.5%		8.8%
Materials	0.0%	0.0%		2.6%
Food	10.6%	7.0%		0.0%
Wages	57.4%	77.4%		68.4%
Infrastructure/ Maintenance	21.3%	2.4%		0.0%
Services	10.6%	3.7%		3.0%
Training	0.0%	0.0%		17.2%
Annual cost per child (2010)	US$1,184.8	US$2,946.4		US$13.0
Total income (2010)	US$2,377,992.4	US$137,942,802.3		US$5,661,307.4
Fees paid by families	Parents pay an average of US$29.3 per month for the community kitchen service.	No payment required except for the community kitchen.	No payment required.	No payment required.

The exchange rate used was the average from December 2010: 3.97 pesos per US dollar.
Source and preparation: the authors.

Table 31. Components of major public child development programs visited in Argentina.

Institution	Directorate-General for the Strengthening of Civil Society, Ministry of Social Development of the City of Buenos Aires	Ministry of Education of the City of Buenos Aires	Ministry of Education of the Province of Entre Rios, Municipality of Villa Paranacito	National Council for Social Policy Coordination (MINEDU, MINSAL and MDS)
Program	**Centros de Protección Infantil**	**Jardines de Infantes Ciudad de Buenos Aires**	**Jardines Infantiles Villa Paranacito**	**Programa Nacional Primeros Años**
Components				
Child care services	Separation into age groups (intervals of 12 months). Center-based care similar to a preschool but with social workers instead of teachers.	Separation into age groups (intervals of 12 months). Center-based care with teachers.	Separation into age groups (intervals of 12 months). Center-based care with teachers.	No child care service provided.
Food services	Breakfast, lunch and snack.	Breakfast, lunch, snack and dinner (evening session only).	Breakfast, lunch, snack and dinner (evening session only).	No food provided.
Nutritional monitoring	The CPIs refer to health centers. They have scales. They have not protocol. Nutritionists oversee menus and the children's weights.	Referral to the nearest hospital.	Referral to the nearest hospital.	Not performed.
Provision of supplements	No supplements provided.	No supplements provided.	No supplements provided.	No supplements provided.
Parental support	Workshops for parents/ informational brochures 4 times per year.	Communication log and meetings.	Communication log and meetings. Generally food and hygiene issues are discussed.	Monthly meetings with families to discuss childrearing issues, run by facilitators.

Source and preparation: the authors.

specialists (early stimulation specialists, speech therapists, nutritionists) and brochures for parents every three months. The *Jardines Infantiles de Buenos Aires* and *Jardines Infantiles de Villa Paranacito* maintain a parent communication log, and they arrange occasional meetings to discuss the children's progress. By contrast, the main focus of *Programa Nacional Primeros Años* is its work with parents, consisting of monthly sessions with families to discuss various issues related to parenting, health and nutrition

Table 32 provides information about program standards for the centers and staff. The CPIs operate out of facilities exclusive to the program (often under agreements with non-governmental organizations). The preschools operate in places exclusively dedicated to them and in community centers or spaces adjoined to a primary school or church. Standards for the CPIs are defined by the program itself, but they report low compliance, especially in the size of the minimum space per child. With the exception of child-to-caregiver ratios, preschools self-report good compliance with other standards. Due to its nature, the *Programa Nacional Primeros Años* only requires that the site where sessions are held be appropriate for games.

Educational profiles are very similar among the programs. It is worth noting that the National Education Act requires the hiring of staff with a teaching degree and the professional supports necessary according to the situation of the children and their families. Although not every jurisdiction complies, progress is being made on this issue. The CPIs have caseworkers (preschool teachers) and caregivers (mothers or students of early childhood education), with the former earning a salary of US$754.8 and the latter US$654.2 per month. The *Jardines*

Infantiles manage two types of personnel: teachers, who must have a degree in early childhood education (i.e., a minimum of four years of post-secondary education) and are responsible for the organization of activities and the management of the children; and teacher aides (known as *maestras celadoras*), who must have at least a high school diploma and are only responsible for working with the children. Teachers receive US$1,068.4 a month and aides receive US$1,006.5. *Primeros Años* also hires for two staff profiles: provincial technical supervisors, who must hold a degree in child care, and community workers, who work as volunteers with no minimum background necessary. These positions receive a monthly stipend of US$45.3 and training as part of their payment.

Table 32. Infrastructure and human capital of major public child development programs visited in Argentina.

Institution	**Directorate-General for the Strengthening of Civil Society, Ministry of Social Development of the City of Buenos Aires**	**Ministry of Education of the City of Buenos Aires**	**Ministry of Education of the Province of Entre Rios, Municipality of Villa Paranacito**	**National Council for Social Policy Coordination (MINEDU, MINSAL and MDS)**
Program	**Centros de Protección Infantil**	**Jardines de Infantes Ciudad de Buenos Aires**	**Jardines Infantiles Villa Paranacito**	**Programa Nacional Primeros Años**
		Quality		
Site where program operates	- Centers exclusive to the program	- Centers exclusive to the program - Community centers	- Centers exclusive to the program - Facilities attached to a church or school	- A place where games can be played
Standards	The program establishes them. Partial compliance (particularly with regard to space requirements).	The Ministry of Education of the City of Buenos Aires establishes them. Compliance, except for some ratios.	The Ministry of Education of the Province of Entre Rios establishes them. Compliance, except for some ratios.	None
Staff profile	Teachers: degree in early childhood education or preschool teacher.	Teachers: degree in early childhood education or preschool teacher, with a copy of the degree certificate (4 years of study) Her role is to run the classroom, and she is in charge of the annual planning for her room.	Teachers: degree in early childhood education or preschool teacher, with a copy of the degree certificate (4 years of study) Her role is to run the classroom, and she is in charge of the annual planning for her room.	Provincial technical supervisors: university degree related to the program with training in areas specific to child development
	Caregivers: students studying to be preschool teachers or mother caregivers	Teacher aides: high school diploma	Teacher aides: high school diploma	Facilitators: they are selected based on personal attributes consistent with the role of assisting families.
Child-to-caregiver ratios (number of children per adult)	2.5 for ages 0 to 1 5 for ages 1 to 2 5 for ages 2 to 4 5 for ages 4 to 6	6 for ages 0 to 1 6.5 for ages 1 to 2 11 for ages 2 to 4 15 for ages 4 to 6	6 for ages 0 to 1 9 for ages 1 to 2 23 for ages 2 to 4 30 for ages 4 to 6	22 for ages 0 to 1 22 for ages 1 to 2 22 for ages 2 to 4
Monthly compensation	US$754.8 for teachers US$654.2 for caregivers	US$1,068.4 for teachers US$1,006.5 for teacher aides	US$629.0 for teachers US$629.0 for teacher aides	US$45.3 for facilitators

Source and preparation: the authors.

The child-to-caregiver ratios at the CPIs are low, with a ratio of two-and-a-half children per adult for ages 0 to 1, and five children per adult for ages 1 to 6. *Jardines de Buenos Aires* has a child-to-caregiver ratio that is higher than that of the CPIs, with six children per adult for ages 0 to 2, 11 for ages 2 to 4, and 15 for ages 4 to 6. Here is where one of the biggest differences between *Jardines de Buenos Aires* and *Jardines de Villa Paranacito* may be seen; the child-to-caregiver ratios at *Jardines de Villa Paranacito* are very high, with six children per adult for ages 0 to 1, 9 for ages 1 to 2, 23 for ages 2 to 4, and 30 for ages 4 to 6. *Programa Nacional de Primeros Años* serves groups of up to 22 families maximum per session.

4.2 Bolivia

The institutional supply of early childhood programs in Bolivia included in this study consists of a child care service program, a nutrition program, and an early stimulation program (children attend weekly sessions at the program *Kallpa Wawa*, most often without their parents).

The program *PAN Manitos - El Alto* (through the Government of La Paz – Municipality of El Alto) is a child care service that began under the auspices of the government of La Paz in 2001, but beginning in 2002, its management was gradually transferred to the municipality. The program serves 4,133 children at 83 centers, focusing on the low-income population. Program targeting is performed through home visits and an enrollment form.

The program *Desnutrición Cero,* created in 2007, forms part of one of Bolivia's major social policies and aims to contribute to the eradication of chronic malnutrition in the country. The program works through nine types of intervention. Although the program focuses on correcting the nutritional deficiencies suffered by children, it also provides health care through bimonthly medical consultations and, in cases where deemed necessary, early stimulation services. It reached 12,301 children through its care units in 2010. There is no data on the number of children served through all program activities, but it is estimated to exceed hundreds of thousands of beneficiaries. This program does not provide child care or parenting services and therefore does not match the main focus of this study.

Lastly, the program *Kallpa Wawa*, founded in 1997 and financially dependent on UNICEF and the Municipality of Tapacarí, is a unique early childhood care program. It originally functioned as a component

Table 33. Overview of major public child development programs visited in Bolivia.

Institution	Government of La Paz - Municipality of El Alto	Ministry of Health	Municipality of Tapacari and UNICEF
Program	**PAN Manitos - El Alto**	**Desnutrición Cero**	**Kallpa Wawa**
Children served (2011)	4,133	12,301	222
Age group served	7 to 60 months	0 to 60 months	0 to 72 months
Centers in operation (2011)	83	106 (UNIs)	20 locales
Staff (2011)	516	182	23
Operating schedule	11 months per year 5 days per week 8 hours per day	12 months per year	8 months per year 1 session per week 3 hours per session
Geographic coverage	Operates only in El Alto	166 locales, mostly rural	1 indigenous community/ Operates only in Tapacari
Target population	Low-income population	Universal	Indigenous population
Targeting method	Targeting based on home visits and enrollment forms.	Targeting based on geographic location and enrollment at SUMI.	Geographic targeting
Fees paid by families	US$5.70	No payment required.	No payment required.
Annual cost per child (2010)	N/A	US$1,179.0	N/A
Total income (2010)	N/A	US$14,502,653.8	N/A

The exchange rate used was the average from December 2010: 7.01 bolivianos per US dollar.
Source and preparation: the authors.

of community-based literacy workshops, providing child care while the parents participated in them. It later became an independent program. Today, it runs weekly three-hour-long sessions with indigenous children from the Municipality of Tapacarí. Parents do not attend these meetings very regularly. The program operates in 20 units, serving 222 children from the community.

Table 33 also shows the financial information available from the programs in Bolivia. At the *PAN – Manitos* program, parents must make a monthly copayment of US$5.70 in order to receive services; however, the other programs are completely free of charge. Financial information is only available for *Desnutrición Cero*, which received a budget of US$14.5 million for 2010 to cover all of the program's activities.

With respect to service delivery, Table 34 shows that *PAN-Manitos* operates child care centers where the children are separated by age and care is provided eight hours per day. These centers offer two meals and two snacks a day, providing 80% of daily caloric requirements. Children are weighed and measured each month, but they receive no nutritional supplements. In contrast, *Desnutrición Cero* has stimulation rooms within the Comprehensive Nutritional Units (UNIs), although they do not offer a child care service but rather stimulation directed toward individual cases. The main focus of this Program is nutrition, which is why it has eight strategic initiatives designed to monitor and improve the nutritional status of children. The program provides 50% of daily caloric needs through basic food baskets. Monitoring of child development takes place every two months, when children go to the doctor. Additionally, the program provides micronutrient sprinkles, vitamin A, iron, folic acid, zinc, and deworming medicine with varying frequency. At the *Kallpa Wawa* program, children attend play and stimulation sessions three hours a week, and the only nutritional service provided by the program is very basic twice-yearly monitoring. The children do not receive nutritional supplements from the program.

Table 34. Components of major public child development programs visited in Bolivia.

Institution	Government of La Paz - Municipality of El Alto	Ministry of Health	Municipality of Tapacari and UNICEF
Program	**PAN Manitos - El Alto**	**Desnutrición Cero**	**Kallpa Wawa**
		Components	
Child care services	Child care centers, separated by age Montessori-based education model.	No child care service provided.	The children attend a center to receive one session of play and stimulation per week.
Food services	2 meals and 2 snacks per day. They provide 80% of daily caloric needs.	8 strategic initiatives designed to monitor and improve the nutritional status of children. They provide 50% of daily caloric needs.	Food service is not provided during sessions.
Nutritional monitoring	Height and weight are measured monthly.	Height and weight are measured bimonthly.	Monitoring is performed every six months.
Provision of supplements	No supplements provided.	Sprinkles are provided at 6 months and 2 years of age; vitamin A every six months; iron at 2 and 3 years of age; folic acid for expectant mothers; zinc and deworming medication.	No supplements provided.
Parental support	Monthly meetings with parents, without the child present. Childrearing, health, nutrition and protection issues are discussed.	Bimonthly consultations during which the child's progress in nutritional terms is examined. Workshops and bimonthly meetings where childrearing practices and health are discussed and work with pregnant mothers.	Awareness workshops are conducted quarterly, where the importance of early childhood is discussed.

Source and preparation: the authors.

Working with parents is an important component of *PAN-Manitos*, which holds monthly meetings with parents to address child rearing, health, nutrition and protection issues. At *Desnutrición Cero*, parents must attend bimonthly medical visits with their children, where the doctor examines their nutritional progress. Additionally, workshops and sessions are held where parents are spoken to about child-rearing practices and health. *Kallpa Wawa* organizes twice-yearly awareness sessions with parents, where the importance of early childhood is discussed.

PAN-Manitos primarily operates out of its own centers. Approximately 60% of these centers meet minimum space standards per child, 70% have outdoor spaces, and between 90% and 100% comply with the rest of the standards related to furnishings and health and safety regulations. *Desnutrición Cero's* UNIs are not required to meet any specific standard in terms of infrastructure or space, although they are generally well furnished. *Kallpa Wawa* has no defined standard for the spaces where sessions are conducted.

With regard to personnel, Table 35 displays the staff profiles and salaries at the three programs. Although it is required that *PAN-Manitos* teachers have some type of training in early childhood in addition to a high school diploma, in practice, this has been difficult to obtain, which is why ongoing staff training programs have been implemented. The teachers in this program receive wages totaling US$107.0 per month. Child-to-caregiver ratios range from five children per adult for ages 0 to 1, to 20 children per adult for ages 4 and 5. The early stimulation specialists at *Desnutrición Cero's* UNIs must hold a professional degree in early stimulation, but given its

Table 35. Infrastructure and human capital of major public child development programs visited in Bolivia.

Institution	Government of La Paz - Municipality of El Alto	Ministry of Health	Municipality of Tapacari and UNICEF
Program	**PAN Manitos - El Alto**	**Desnutrición Cero**	**Kallpa Wawa**
		Quality	
Site where program operates	- Centers exclusive to the program - Modified family homes - Community centers - Facilities attached to a church or school	- Comprehensive Nutrition Units (UNIs) - Health centers - Community centers	- Schools - Community centers
Standards	60% of centers meet minimum space requirements per child. 70% have space for outdoor activities. Centers are well furnished and have a complete set of materials. 90% of centers comply with health and safety regulations.	UNIs have a good supply of teaching materials. Other standards do not apply.	There are no standards for the sites where sessions are held.
Staff profile	Educators: high school diploma, with some training in child care. 1 year of experience.	UNI staff: there is no specific profile. Must be a specialist in stimulation.	Teachers: they must have completed high school. They support the person in charge of working with the children by planning their activities. Those responsible for working with the children: no minimum education level required.
Child-to-caregiver ratios (number of children per adult)	5 for ages 0 to 1 6 for ages 1 to 2 15 for ages 2 to 4 20 for ages 4 to 5	N/A	9.1 for ages 0 to 5
Monthly compensation	US$107.0	US$959.9	US$285.3 for teachers US$32.8 for those responsible of working with the children

Source and preparation: the authors.

nature, the program does not establish maximum child-to-caregiver ratios. These professionals receive a salary of US$959.9 per month. *Kallpa Wawa* has a small group of teachers who support those responsible for stimulation in the planning of their activities, and they must have a high school diploma. The staff members directly responsible for the children's care are not required to have a minimum level of education. The child-to-caregiver ratio is 9.1 children per adult in all age ranges, since children are not separated into different age groups during the session.

4.3 Brazil

The public provision of early childhood services in Brazil is completely decentralized, which makes it impossible to have a representative sample of how early childhood programs operate in this country. With this limitation, programs were visited in three municipalities: Rio de Janeiro, Fortaleza and Sobral (a large city, a medium one, and a small one). Table 36 displays the main features of the programs visited.

Rio de Janeiro is the second largest city in Brazil with more than six million inhabitants. The city's early childhood program *Espacios de Desarrollo Infantil* was consolidated in 2009 as an initiative of the local government. Currently, the program serves more than 130,000 children from vulnerable families through centers providing child care from 4 to 10 hours per day, depending on the needs of the parents. Slots are prioritized for vulnerable households through the geographic location of the centers and through a lottery at each center.

Fortaleza, in the state of Ceará, has 2.5 million inhabitants. The program *Atención en Educación Infantil de la Secretaría Municipal de Educación* serves more than 32,000 children between the ages of 1 and 6. Created in 2002, the program aims to provide universal coverage, and it does not target its slots. The program has 135 centers that operate between four and 10 hours a day, depending on the needs of the community.

Sobral, in the state of Ceará, has 188,000 inhabitants. *Proyecto de Primera Infancia* serves more than 8,000 children at 45 centers, operating between four and 10 hours per day. The difference between this service and those mentioned above lies

Table 36. Overview of major public child development programs visited in Brazil.

Institution	Municipal Secretariat of Education of Rio de Janeiro	Municipal Secretariat of Education of Fortaleza	Municipal Secretariat of Education of Sobral
Program	**Espacio de Desarrollo Infantil**	**Atención en Educación Infantil**	**Proyecto de Primera Infancia**
Children served (2011)	130,006	32,232	8,000
Age group served	7 to 66 months	13 to 72 months	0 to 72 months
Centers in operation (2011)	1,269	135	45
Staff (2011)	12,548	4,638	572
Operating schedule	11 months per year 5 days per week 4.5 to 10 hours per day, depending on the type of center.	12 months per year 5 days per week 4 to 10 hours per day, depending on the type of center.	9 months per year 5 days per week 4 to 10 hours per day, depending on the type of center.
Geographic coverage	Local coverage - Rio de Janeiro	Local coverage - Fortaleza	Local coverage - Sobral
Target population	- More vulnerable families - Beneficiaries of the program Familia Carioca	Universal	Working mothers, for slots for 0 to 18 months
Targeting method	The program prioritizes slots geographically and through a lottery that takes into account conditions of vulnerability.	No targeting.	No targeting.

Source and preparation: the authors.

in the fact that this service only operates during the academic year, i.e. nine months per year. Although the program provides universal care, it has a prioritization process that favors working mothers with children aged 0 to 18 months.

Although it was not possible to obtain financial information from the programs in Sobral, the information from Rio de Janeiro and Fortaleza reveals valuable data about the distribution of costs and program budgets. The program's annual

Table 37. Income and expenditures of major public child development programs visited in Brazil.

Institution	Municipal Secretariat of Education of Rio de Janeiro	Municipal Secretariat of Education of Fortaleza	Municipal Secretariat of Education of Sobral
Program	**Espacio de Desarrollo Infantil**	**Atención en Educación Infantil**	**Proyecto de Primera Infancia**
Total expenditures (2010)	US$158,963,812.3	US$42,472,892.0	N/A
Infrastructure/ Maintenance	15.2%	2.6%	
Wages	48.4%	52.2%	
Training	0.0%	0.3%	
Food	4.4%	3.6%	
Administrative expenses	0.0%	6.1%	
Services	28.2%	0.0%	
Materials	3.8%	35.3%	
Total income (2010)	US$231,869,842.1	N/A	
Annual cost per child (2010)	US$1,783.5	US$1,317.7	
Fees paid by families	No payment required.	No payment required.	No payment required.

The exchange rate used was the average from December 2010: 1.69 Brazilian reals per US dollar.
Source and preparation: the authors.

Table 38. Components of major public child development programs visited in Brazil.

Institution	Municipal Secretariat of Education of Rio de Janeiro	Municipal Secretariat of Education of Fortaleza	Municipal Secretariat of Education of Sobral
Program	**Espacio de Desarrollo Infantil**	**Atención en Educación Infantil**	**Proyecto de Primera Infancia**
Components			
Child care services	Child care centers. Rooms divided by age.	Child care centers. Rooms divided by age.	Child care centers. Rooms divided by age.
Food services	All meals are provided including 2 snacks per day. They cover 100% of daily caloric needs.	All meals are provided including 2 snacks per day. They cover 100% of daily caloric needs. Only children under 2 receive breakfast.	All meals are provided including 2 snacks per day. They cover 100% of daily caloric needs. Only children under 2 receive breakfast.
Nutritional monitoring	Development is monitored on an annual basis with an instrument called the Ages and Stages Questionnaires. Information is stored and analyzed for use and future reference.	Monitoring is performed at centers with visits from nutritionists every six months. The information is shared with families and is used in menu planning.	Performed at the school with variable frequency, as it is the responsibility of the centers. The data is only saved at some centers and it is not used.
Parental support	A parenting school is offered, which convenes with varying frequency to address issues of child development.	Sessions with parents where child development, the educational process and other issues are discussed, according to the needs of the parents.	Annual program with UNICEF to work with parents on teaching methods.

Source and preparation: the authors.

budget in Rio de Janeiro was US$231.9 million in 2010, with expenses totaling US$158.9 million. The largest expense categories were wages (48%), followed by services (28%) and infrastructure and maintenance costs (15%). The annual cost per child amounts to US$1,783.5. Fortaleza operates on an annual budget of US$42.4 million, with a cost of US$1,317.7 per child per year. Children's families do not pay for services in any of the three cities.

The child care services and food are similar in all three programs. The centers offer lunch and two snacks, with the intent to cover 100% of daily caloric requirements. Additionally, they provide breakfast to children under 2. None of the programs provides nutritional supplements.

Monitoring of the children's development is performed on an annual basis in Rio de Janeiro through the Ages and Stages Questionnaire. This instrument is designed to detect delays in different dimensions of development: motor skills, communication, problem solving, and social-emotional development. The information is analyzed and used for program planning. In Fortaleza, the centers receive a twice-yearly visit from a nutritionist who weighs and measures the children. In this case, the information is shared with families and is used in menu planning. The process in Sobral is more basic. The frequency of height and weight checks is not defined. When the children are weighed and measured, this information is not stored nor is it used for planning or monitoring activities.

With respect to the programs' work with families, Rio de Janeiro offers a "parenting school," where mothers and fathers meet with varying frequency to address issues of risk prevention and child development. In Fortaleza, sessions are held on child development and the educational process. In Sobral, the Secretariat has a special UNICEF program that works with parents on teaching methods.

Table 39. Infrastructure and human capital of major public child development programs visited in Brazil.

Institution	Municipal Secretariat of Education of Rio de Janeiro	Municipal Secretariat of Education of Fortaleza	Municipal Secretariat of Education of Sobral
Program	**Espacio de Desarrollo Infantil**	**Atención en Educación Infantil**	**Proyecto de Primera Infancia**
		Quality	
Site where program operates	- Centers exclusive to the program	- Program centers - Facilities attached to a church or school	- Centers exclusive to the program - Facilities attached to a church or school
Standards	Some aspects of staffing and space are not regulated, but they meet all other regulations satisfactorily. Minimum of 1 square meter per child.	Space regulations met 50% to 80% of the time. Annual inspections of all centers. Minimum of 1.5 square meters per child	Compliance with quality standards. Frequent monitoring of centers for safety and health compliance.
Staff profile	Teachers: professional degree in teaching.	Teachers: professional degree in teaching.	Teachers: professional degree in teaching.
	Aides: must have completed high school. They are in charge of hygiene, care and feeding.	Aides: must have high school diploma with a concentration in teaching. No minimum experience required, and they receive the same training as teachers.	Aides: same profile as teachers.
Child-to-caregiver ratios (number of children per adult)	4.2 for ages 0 to 2 7.0 for ages 2 to 4 8.3 for ages 4 to 6	4.0 for ages 1 to 2 5.5 for ages 2 to 4 18.0 for ages 4 to 6	2.5 for ages 0 to 1 3.8 for ages 1 to 2 8.8 for ages 2 to 4 10.0 for ages 4 to 6
Monthly compensation	US$826.2 for teachers US$469.8 for aides	US$885.3 for teachers US$368.9 for aides	US$826.2 for teachers and aides

Source and preparation: the authors.

The three cities have exclusive facilities to care for children, although some of the centers are attached to a school or church. In terms of regulations, Rio de Janeiro has no defined standards for materials or equipment, but it does have health and safety protocols, with which the program reports good compliance. In addition, it has a very low space standard per child in comparison to other programs in the region—just one square meter per child. Fortaleza reports 50% compliance with space standards and 80% with staffing standards, with annual inspections and a minimum space per child standard of one-and-a-half square meters. Centers in Sobral have worked hard to conduct frequent supervision, which is why they report that they maintain a high level of standards compliance, although there is no quantitative evidence to support this claim.

The educational profiles of the teachers are high, with preference given to persons with a college degree in education. Additionally, they maintain low child-to-caregiver ratios, even among the older children, with ratios close to four for children ages 0 to 1 and close to ten for children ages 4 to 6 (except in Fortaleza, where the ratio is 18 children per adult for this age range). Monthly salaries range from US$400 for aides to over US$800 for teachers, regardless of the city.

4.4 Chile

Three public early childhood care programs were visited in Chile— two center-based child care services and one parenting program.

The centers now belonging to *Fundación Integra* first opened their doors in 1975, with the goal of reducing the existing malnutrition rates at that time. In 1990, they became part of *Fundación Integra*, a key branch of the Office of the First Lady. With this change, the program redirected its efforts toward the comprehensive care of children. The centers serve 70,597 children under the age of 5, and they seek to assist vulnerable, low-income populations. Program targeting is achieved through a socioeconomic file.

Jardines Infantiles de la JUNJI (National Board of Day Care Centers) centers are the main providers of public child care services in the country, with 172,900 children served, more than 55,000 of whom are served directly through program centers, and the rest through subsidized

Table 40. Overview of major public child development programs visited in Chile.

Institution	Ministry of Education/Office of the First Lady	National Board of Day Care Centers (JUNJI)	National Board of Day Care Centers (JUNJI)
Program	**Fundación Integra**	**Jardines Infantiles de la JUNJI**	**Conozca a su Hijo (CASH)**
Children served (2011)	70,597	172,900	3,656
Age group served	0 to 60 months	7 to 60 months	0 to 72 months
Centers in operation (2011)	988	3,071	N/A
Staff (2011)	12,668	11,051	12
Operating schedule	10.5 months per year 5 days per week 8 hours per day	11 months per year 5 days per week 8 to 11 hours per day	10 months per year 1 session per week 3 hours per session
Geographic coverage	Nationwide	Nationwide - 134 locales	Nationwide - mainly rural
Target population	- Low-income population - Conditions of vulnerability	- Low-income population - Conditions of vulnerability - Working mothers	- Conditions of vulnerability - Rural population
Targeting method	Targeting based on family income. Must be in first and second quintiles (poverty). The program also uses a vulnerability assessment worksheet.	The score from the Social Protection Worksheet (official government instrument) is used, plus institutional criteria.	Targeting based on income and geographic location of the home.

Source and preparation: the authors.

slots at private or third-party-operated centers. Created under national law in 1970, the program targets children under 5 from low-income families and the children of working mothers. It employs a national instrument (the social protection worksheet) for targeting.

JUNJI's *Conozca a su Hijo* (CASH) program came about in the late 1980s at the Ministry of Education. It originated with the goal of offering comprehensive care to children under the age of 6 whose families live in communities with high geographic dispersion. Coverage in 2011 reached 3,656 mothers. Its target population is socially-vulnerable mothers living in rural areas. Targeting is based on the mothers' geographic location and their income level.

With regard to budgets, Table 41 documents that *Fundación Integra* receives annual income of US$230.4 million, compared to US$430.3 million for *Jardines de la JUNJI* and US$1.9 million for the CASH program. In all three cases, the source of the funds is mainly the national government. However, private sector contributions do play an important role in the first program. *Fundación Integra* works on a bidding model where a payment is delivered to the centers for services rendered. The centers must meet the program's standards and guidelines, which address topics such as staff profiles and salaries. 82% of the program's resources are transferred to the centers to cover their operating expenses. Additionally, the program provides food and materials, dedicating 11% of its resources to these expenditure categories. *Jardines de la JUNJI* are direct service providers, with spending primarily distributed among salaries (39%), payment of services (31%), and infrastructure and maintenance costs (22%). CASH program expenses are in keeping with the type of attention provided; the mothers who run the sessions are volunteers and meetings are held at community centers whose use is free. Most of the expenses cover services (50%), followed by salaries and stipends (27%), and materials (23%).

None of the programs requires parents to make payments for services, and the annual costs per child are US$3,263.8 for *Fundación Integra*, US$2,895 for *Jardines de la JUNJI*, and US$598.7 for CASH.

Fundación Integra and *Jardines de la JUNJI* offer child care services, education, food, and parental support, and they have similar characteristics. They are both guided by the national strategy *Chile Crece Contigo.* They serve children eight hours per day. They provide breakfast, lunch and a daily snack, covering between 60 and 70% of the children's caloric needs. Nutritional monitoring is performed twice-yearly at *Fundación Integra* centers and monthly at JUNJI centers. In both cases,

Table 41. Income and expenditures of major public child development programs visited in Chile.

Institution	Ministry of Education/Office of the First Lady	National Board of Day Care Centers (JUNJI)	National Board of Day Care Centers (JUNJI)
Program	**Fundación Integra**	**Jardines Infantiles de la JUNJI**	**Conozca a su Hijo (CASH)**
Total expenditures (2010)	US$230,413,203.1	US$430,329,551.7	US$1,907,515.4
Wages	N/A	39.4%	26.9%
Training		0.2%	0.0%
Administrative Expenses		6.6%	0.0%
Infrastructure/ Maintenance		22.3%	0.0%
Services		30.6%	50.0%
Food		0.0%	0.0%
Materials		1.0%	23.1%
Total income (2010)	US$230,413,203.1	US$500,544,566.3	US$2,188,886.4
Annual cost per child (2010)	US$3,263.8	US$2,895.0	US$598.7
Fees paid by families	No payment required	No payment required	No payment required

The exchange rate used was the average from December 2010: 473.9 Chilean pesos per US dollar.
Source and preparation: the authors.

the information collected from these checks is used to verify that there are no problems with the children's nutrition and to plan activities. None of the programs provides nutritional supplements. Work with parents occurs through bimonthly sessions where child rearing, learning, health and nutrition issues are discussed.

The parenting program CASH selects volunteer mothers from rural communities and trains them in various skills, especially in the areas of nutrition, health and play. Later, the volunteers meet with the mothers in their community once a week at a community center or in a private home. In these spaces, the volunteer mother shares what she has learned. Mothers attend these sessions with their children, who are cared for in a separate room by a helper. Generally, during this time children play with each other or simply take a nap. The helper in charge of taking care of them does not receive any training on interacting with or stimulating young children.

Chile's centers and daycares are regionally recognized for their efforts between 2005 and 2009 to expand coverage and, at the same time, achieve a high level of quality. This is reflected in the standards compliance reported by the programs themselves and in the infrastructure they have adopted. Additionally, systematic monitoring of the centers, follow-up with problem cases, and an accreditation system are in place.

The educational profile of the staff is very high at both *Fundación Integra* and JUNJI, where even the caregivers must possess a professional degree in early childhood care. In the case of the CASH program, since those who run the sessions are volunteer mothers, only a high school diploma is required. Child-to-caregiver ratios are 5.2 children per adult for ages 0 to 2 at *Fundación Integra* and 4.6 for ages 0 to 2 years at JUNJI; these increase to 15.6 and 16, respectively, for the 4-to-6 age group. Low child-to-caregiver ratios for the youngest ages guarantee high

Table 42. Components of major public child development programs visited in Chile.

Institution	Ministry of Education/ Office of the First Lady	National Board of Day Care Centers (JUNJI)	National Board of Day Care Centers (JUNJI)
Program	**Fundación Integra**	**Jardines Infantiles de la JUNJI**	**Conozca a su Hijo (CASH)**
Components			
Child care services	Attention and care provided 8 hours per day at dedicated program centers.	They serve children between the ages of 45 days and 5 years at their own co-funded daycare centers. They operate 8 to 11 hours per day.	While the sessions are held with parents, an aide takes care of the children in a separate room.
Food services	They provide breakfast, lunch and a snack. They cover 60% of daily caloric needs.	They provide breakfast, lunch and 2 snacks. They cover 70% of daily caloric needs.	Sometimes a snack is provided during the session.
Nutritional monitoring	Nutritional assessments at health centers every six months. The information is used to identify problems and plan activities.	Monthly height and weight checks at the center. Data systematization is performed in order to plan activities.	The children's growth is not monitored.
Provision of supplements	No supplements provided.	No supplements provided.	No supplements provided.
Parental support	Sessions are held bimonthly to discuss issues related to childrearing practices and working with the child. Additionally, good communication is maintained with parents on issues of nutrition, health and the protection of rights through a journal or traveling notebook.	Bimonthly meetings with parents to work on issues related to childrearing and learning methods, health, and nutrition.	Work with parents consists of training a volunteer mother from the community, who then, in turn, teaches the other mothers. Sessions address topics as varied as how to play with the child and how to build toys from basic materials, to the child's basic hygiene and food needs.

Source and preparation: the authors.

Table 43. Infrastructure and human capital of major public child development programs visited in Chile.

Institution	Ministry of Education/ Office of the First Lady	National Board of Day Care Centers (JUNJI)	National Board of Day Care Centers (JUNJI)
Program	**Fundación Integra**	**Jardines Infantiles de la JUNJI**	**Conozca a su Hijo (CASH)**
		Quality	
Site where program operates	Mainly at centers exclusive to the program.	Mainly at centers exclusive to the program.	Mainly in community centers.
Standards	Strong compliance with all established standards, including spaces, furnishings, health and safety. Monitoring of centers is conducted every month.	Strong compliance with regulations, although a little less strict than Fundación Integra in terms of its regulations. Monitoring of centers is conducted every three months.	No standards or regulations for the spaces or facilities where sessions are conducted.
Staff profile	Preschool directors: requires a degree in early childhood education. They are responsible for the administrative and educational management of the preschools.	Preschool teacher: must have a degree in early childhood education. They work directly with the children.	Supervisors: must have university training.
	Educators: must have a degree in early childhood education. They work directly with the children.	Preschool aides: they must have certification in early childhood education.	Volunteer mothers: no minimum education requirement.
	Aides: they must have certification in early childhood education.		
Child-to-caregiver ratios (number of children per adult)	5.2 for ages 0 to 2 14.1 for ages 2 to 4 15.6 for ages 4 to 6	4.6 for ages 0 to 2 10.7 for ages 2 to 4 16.0 for ages 4 to 6	15.0 for ages 0 to 6
Monthly compensation	US$1,420.8 for directors US$1,064.6 for teachers US$688.8 for aides	US$865.1 for teachers US$622.4 for aides	N/A

Source and preparation: the authors.

quality service. CASH has groups of up to 15 mothers per volunteer. This implies that the number of children per helper during the session could reach up to 20.

Although CASH staff is composed of volunteers, the program offers financial incentives to recognize their efforts. For their part, the child care services offer competitive salaries ranging from US$622.4 for JUNJI aides to US$1,420.8 for the directors of *Fundación Integra* centers.

4.5 Colombia

The Colombian programs included in this study correspond to three child care services, two of which are municipal programs and the third being one of the largest programs in terms of coverage in Latin America.

The *Buen Comienzo* program of the city government of Medellin offers child care services. It was created in 2004 as an initiative of the Mayor's Office to provide nutritional services to children who were not being served by the Colombian Family Welfare Institute. In 2008, it received a significant budget boost that changed the program's objective. Since then, the program has supported children from the time of pregnancy until they begin elementary school. This involves a great deal of effort in terms of working with pregnant mothers, including special attention to the areas of health, nutrition and development. With coverage of 83,000 children under age 5, the program

reports that it covers 100% of its target population, which consists of vulnerable, low-income families.

Proyecto para una Infancia y Adolescencia Feliz y Protegida Integralmente de la Secretaría de Integración Social de la Alcaldía de Bogotá, established in 2004, seeks to serve children under 5 through different program types operating in community homes, preschools and daycare centers. These program types differ in the quality of their infrastructure and the size of the groups they serve. They cover nearly 48,000 children under the age of 5, giving priority to children without birth certificates, and in areas with high concentrations of poverty, high infant mortality and prevalence of malnutrition.

Lastly, *Hogares Comunitarios de Bienestar* (HCBs), created in 1974 as a poverty eradication program, represent the Colombian Family Welfare Institute's (ICBF) emblematic form of early childhood care. Care is provided in community mothers' adapted homes. They focus on children under age 6. The HCBs offer care, food and early stimulation. In recent years, there have been efforts to improve quality. The program achieves coverage of more than 1.2 million children across the country. The program targets vulnerable, low- income populations, using the Beneficiary Selection System for Social Programs (SISBEN).

The *Hogares Comunitarios de Bienestar* program spends US$353.7 per year per child and has an annual budget of US$408.7 million. The main expenditure categories are food and stipends for the community mothers (who do not have an employment relationship with the program). The homes also receive a portion of their funding through a parental co-payment of US$8.10 per month. The

Table 44. Overview of major public child development programs visited in Colombia.

Institution	Secretariat of Education, Secretariat of Health, and Secretariat of Social Integration of Medellin	Secretariat of Social Integration of Bogota	Colombian Family Welfare Institute
Program	**Buen Comienzo**	**Proyecto para una Infancia y Adolescencia Feliz y Protegida Integralmente**	**Hogares Comunitarios de Bienestar Familiar**
Children served (2011)	83,000	47,943	1,219,098
Age group served	0 to 60 months	0 to 60 months	0 to 72 months
Centers in operation (2011)	691	357	72,277
Staff (2011)	4,021	4,535	79,062
Operating schedule	10.5 months per year 5 days per week/1 day per week for children under the age of 1 8 hours per day/1.5 hours per day for children under the age of 1	11 months per year 5 days per week 10 hours per day	10 months per year 5 sessions per week 8 hours per day
Geographic coverage	Local coverage - Medellin	Local coverage - Bogota	Nationwide coverage
Target population	- Low-income population - Conditions of vulnerability	- Children without birth certificates - Concentration on the poor - High maternal and child mortality rate - Areas with a high rate of malnutrition	- Low-income population - Conditions of vulnerability - Social risk
Targeting method	Targeting using SISBEN levels 1 and 2 (out of 6); the SISBEN system compiles socioeconomic and quality-of-life characteristics.	The program uses its own targeting instrument and geographic location of the centers to determine beneficiaries.	Targets levels 1 and 2 of SISBEN (out of 6).

Source and preparation: the authors.

Table 45. Income and expenditures of major public child development programs visited in Colombia.

Institution	Secretariat of Education, Secretariat of Health, and Secretariat of Social Integration of Medellin	Secretariat of Social Integration of Bogota	Colombian Family Welfare Institute
Program	**Buen Comienzo**	**Proyecto para una Infancia y Adolescencia Feliz y Protegida Integralmente**	**Hogares Comunitarios de Bienestar Familiar**
Total expenditures (2010)	US$1,106,366.1	N/A	US$408,657,128.4
Administrative Expenses	0.0%		0.0%
Materials	0.6%		3.3%
Food	0.0%		50.6%
Wages	96.8%		43.3%
Infrastructure/Maintenance	0.0%		0.0%
Services	2.6%		2.7%
Training	0.0%		0.0%
Annual cost per child (2010)	US$725.0		US$353.7
Total income (2010)	US$60,174,732.7		US$431,170,809.8
Fees paid by families	No payment required	No payment required	They pay an average of US$8.10 per month.

The exchange rate used was the average from December 2010: 1,915.5 Colombian pesos per US dollar.
Source and preparation: the authors.

other two programs do not require any payment from parents. *Buen Comienzo's* annual cost per child is US$725, with annual expenses totaling of US$1.1 million.

The characteristics of the three child care programs are similar. The *Buen Comienzo* program only works with children over the age of 1 in its centers, and it operates 5 to 8 hours a day. The *Alcaldía de Bogotá* program offers three types of care that differ in quality and administrative management. They are open 8 to 10 hours per day. The HCBs have the greatest number of program modalities, with the community home being the most common. These homes serve 12 to 14 children of all ages, under the responsibility of a single caregiver. When neighborhoods and communities have a high density of community homes, the caregivers can group together. This facilitates care and allows the children to be divided into groups according to their age. In addition to traditional community homes, there are group and multiple homes as well as daycare centers (known as *jardines sociales*). The latter is a more recent center-based service that seeks to achieve higher quality (through better infrastructure, equipment, a pedagogical model and professional staff).

All three programs provide lunch and two snacks a day, covering between 70% and 80% of the children's daily caloric requirements. The children are weighed and measured every two months at *Buen Comienzo*, every six months at *Alcaldía de Bogotá*, and every three months at the HCBs. In all cases, the information is systematized and used to improve the menus or to identify individual problems. In the case of the HCBs, only 20% of the anthropometric data collected is systematized, due to the size of the program's coverage. Lastly, *Buen Comienzo* does not provide nutritional supplements; however, *Alcaldía de Bogotá* distributes vitamin A, iron and deworming medicine on a monthly basis, and the HCBs provide micronutrient sprinkles, also on a monthly basis.

Working with parents is an essential component of the *Buen Comienzo* program, and this is done through monthly meetings that begin during pregnancy and continue into early childhood. At *Alcaldía de Bogotá*, work with parents consists of twice-yearly meetings that address issues of health, nutrition, child care and development. The HCBs hold monthly training sessions on abuse, health and child care.

Table 46. Components of major public child development programs visited in Colombia.

Institution	Secretariat of Education, Secretariat of Health, and Secretariat of Social Integration of Medellin	Secretariat of Social Integration of Bogota	Colombian Family Welfare Institute
Program	**Buen Comienzo**	**Proyecto para una Infancia y Adolescencia Feliz y Protegida Integralmente**	**Hogares Comunitarios de Bienestar Familiar**
Components			
Child care services	Various types of center-based care provided for children over 1, including daycare centers operating 5 to 8 hours per day and preschools for 8 hours.	Care is available from 8 to 10 hours per day at three types of centers: community homes, daycare centers, and preschools; with the latter being of the highest quality.	Program operates 8 hours per day with different forms of care, mainly at modified family homes; community staff is in charge of care.
Food services	They provide lunch and 2 snacks per day. The goal is to provide 80% of daily caloric needs at centers open for 8 hours and 27% at centers open for 5 hours.	They provide lunch and 2 snacks per day. They provide 70% of daily caloric needs.	They provide lunch and 2 snacks per day. They aim to provide 70% of daily caloric needs.
Nutritional monitoring	Children are weighed and measured at the centers every 2 months. The information gathered is analyzed to identify problems.	The children's growth is monitored every 6 months. Information is analyzed using special software and action is taken.	The children's height and weight are monitored on a quarterly basis. The information is analyzed with a system called Metrix. 20% of the total data is stored.
Provision of supplements	Neither nutritional supplements nor fortified foods are provided.	They provide vitamin A, iron and deworming medication every month.	Bienestarina (micronutrient sprinkles) is provided daily.
Parental support	One type of care is based out of the family home and within the community, where they work with the families of children who attend the program, especially mothers, who sign up with the program at the time of pregnancy. Monthly sessions address nutrition, health and child care issues.	Work with parents consists of twice-yearly meetings that address issues of health, nutrition, child care and development. The children's learning progress is reviewed every 4 months with the parents.	Training sessions on health, child care, abuse and other issues are conducted on a monthly basis.

Source and preparation: the authors.

The *Buen Comienzo* program stands out for its use of dedicated, specialized child care facilities. Most of its centers have undergone major renovations or have been built for the program. *Alcaldía de Bogotá* also has dedicated infrastructure, although it is generally a bit old and does not comply with all standards and regulations. It is also distinguished by its use of remodeled community centers. The infrastructure used by the HCB is the home of the community mother in charge of care. The fact that the same mother must provide child care, cook, and keep her house in order affects the quality of the care she can give the children. When homes are grouped together, there are greater options for improving the quality of the infrastructure and care.

Buen Comienzo centers meet all basic equipment and safety needs. However, they have problems with classroom space. Only 45% of the centers meet the minimum amount of space per child required by the program. *Alcaldía de Bogotá* has very strict monitoring and accreditation processes for the centers. They have found that only 29% of the centers are fully compliant with health regulations and 68% with security regulations. At the HCBs, standards compliance is low and only occurs in 10% to 30% of cases. This is one of the main reasons that led to the grouping of centers through a center-based model and, subsequently, improved quality.

Of the three programs, *Buen Comienzo* has the lowest child-to-caregiver ratios with 3.7 children per adult for ages 0 to 2, and 6.2 for ages 2 to 6. In contrast, the child-to-caregiver ratios of the HCBs are very high for all ages, with 10 children

Table 47. Infrastructure and human capital of major public child development programs visited in Colombia.

Institution	Secretariat of Education, Secretariat of Health, and Secretariat of Social Integration of Medellin	Secretariat of Social Integration of Bogota	Colombian Family Welfare Institute
Program	**Buen Comienzo**	**Proyecto para una Infancia y Adolescencia Feliz y Protegida Integralmente**	**Hogares Comunitarios de Bienestar Familiar**
		Quality	
Site where program operates	- Centers exclusive to the program - Community centers	- Centers exclusive to the program - Community centers	- Modified homes - Facilities attached to churches or schools - Centers exclusive to the program - Community centers
Standards	Strong compliance with staffing, health and safety standards. 45% of centers meet minimum space requirements per child.	Between 70% and 90% compliance with quality standards. 29% of centers fully meet health regulations and 68% comply with safety regulations.	Basic compliance with quality standards at centers. Between 10% and 30% of community homes meet minimum quality standards.
Staff profile	Teachers: degree in early childhood education, teaching or related subjects.	Teachers: degree in early childhood education, or a certificate in early childhood education with 2 years of experience.	Community mothers: a technical/vocational high school diploma is preferred.
	Aides: family members and child care aides with experience in early childhood, who support the development of educational activities; community mothers and FAMI hired by the ICBF.	Educational Aides: high school diploma with a concentration in teaching, high school or technical student with over 10 years of experience.	
Child-to-caregiver ratios (number of children per adult)	3.7 for ages 0 to 2 6.2 for ages 2 to 6	8.3 for ages 0 to 2 12.9 for ages 2 to 4 16.6 for ages 4 to 6	10.0 for ages 0 to 2 15.0 for ages 2 to 6
Monthly compensation	US$652.6 for teachers US$261.0 for aides	US$759.1 for teachers US$621.3 for educational aides	US$146.2 for community mothers

Source and preparation: the authors.

per adult for ages 0 to 2, and 15 for ages 2 to 6. Plus, children are not divided into groups according to their age. *Buen Comienzo's* teachers receive a salary of US$652.6 per month and aides receive US$261.0. At *Alcaldía de Bogotá*, teachers receive US$759.1 per month and aides receive US$621.3. At the HCBs, community mothers only receive a stipend of US$146.2 per month.

4.6 Costa Rica

The Costa Rican program analyzed in this study is the Ministry of Health's CEN-CINAI. It was established in 1951 as a food program for children and pregnant mothers at risk of malnutrition. In 1971, preschool education was introduced and the centers became CEN (Education and Nutrition Centers). In 1975, CINAIs (Child Nutrition and Development Centers) were opened. In 2010, the National CEN-CINAI Office was created. The program provides nutrition services to 92,054 children and child care services to 31,624 children between 3 and 72 months old. Slots are prioritized for malnourished children and low-income populations, and targeting is accomplished through an income statement and by the location of the centers. The annual cost per child is US$574.8. Disaggregated data was not obtained for the preschool service. The program has an annual budget of US$71.1 million, and parents can make voluntary monthly contributions.

Child care services are provided under two care models: the CENs, which operate

Table 48. Overview of major public child development programs visited in Costa Rica.

Institution	Ministry of Health
Program	**CEN-CINAI**
Children served (2011)	31,624 at centers/92,054 through nutrition services
Age group served	3 to 72 months
Centers in operation (2011)	624
Operating schedule	12 months per year 5 days per week Between 8 and 12 hours per day
Geographic coverage	82 locales
Target population	- Children suffering from malnutrition - Low-income families at social risk
Targeting method	The program uses an income statement and geographic location of the centers to determine beneficiaries.
Annual cost per child (2010)	US$574.8
Total income (2010)	US$71,095,202.4
Fees paid by families	Voluntary contributions.

The exchange rate used was the average from December 2010: 502.1 colones per US dollar.
Source and preparation: the authors.

Table 49. Components of major public child development programs visited in Costa Rica.

Institution	Ministry of Health
Program	**CEN-CINAI**
Components	
Child care services	Two forms of center-based care: CEN and CINAI. The CINAIs are centers that operate 12 hours per day, and the CENs operate 8 hours per day.
Food services	The CENs provide 2 meals per day and the CINAIs 3. They provide 70% of daily caloric needs.
	CEN-CINAI has a food assistance program for families through community visits or sessions. The program provides 1.6 kg of milk per month and/or distributes monthly food rations to families with malnourished children. The provision of food is always accompanied by educational sessions for parents and children.
Nutritional monitoring	Height and weight are measured every 6 months. Special attention is given to cases of malnutrition (measured every 3 months).
Provision of supplements	Foods fortified with various micronutrients.
Parental support	Support program addressing the task of childrearing and socialization. Monthly meetings with parents.

Source and preparation: the authors.

eight hours per day, and the CINAIs, which have better infrastructure and operate 12 hours per day. The CENs provide two meals a day and the CINAIs three, but both seek to guarantee 70% of the daily caloric requirement. They also provide a monthly ration of fortified foods to families with malnourished children. Children at the CEN-CINAI centers are weighed and measured every six months, although malnourished children are monitored every three months.

Services are offered at centers used exclusively by the program. Annual inspections are conducted, and although they have imposed regulations governing the minimum space per child (1.5 square meters), it is not known what percentage of centers meet these standards.

Regarding staff profiles, the director of each CINAI must hold a degree in preschool education and have at least two years of experience. Teachers must be high school graduates with two years of training in preschool education, and teacher aides must have completed up through the third year of high school. All staff receive a salary of US$618, with pay increases for seniority. The child-to-caregiver ratios are 3.2 children per adult for ages 0 to 1, 3.6 for ages 1 to 2, 13 for ages 2 to 4, and 24 for ages 4 to 6.

Table 50. Infrastructure and human capital of major public child development programs visited in Costa Rica.

Institution	Ministry of Health
Program	**CEN-CINAI**
Quality	
Site where program operates	- Program centers - Community centers
Standards	Minimum space requirement of 1.5 square meters per child. Although the program has regulations for infrastructure and space, it does not know what percentage of the centers comply with these regulations. Annual inspections with possible closure of centers.
Staff profile	CINAI Directors (CENs do not have directors): degree in preschool education. Minimum of 2 years of experience. Manages the CINAI and works with the children.
	Preschool teacher or civil service assistant: high school diploma with 2 years of preschool training. Minimum 2 years of related experience. Works directly with the children.
	Assistant worker: must have completed the third year of high school. Assists in the care of children under 2.
Child-to-caregiver ratios (number of children per adult)	3.2 for ages 0 to 1 3.6 for ages 1 to 2 13.0 for ages 2 to 4 24.0 for ages 4 to 6
Monthly compensation	US$618.0 with negotiated annual increases.

Source and preparation: the authors.

4.7 Ecuador

In Ecuador, programs of the Institute for Children and Families (INFA) were visited.

The *Centros Infantiles del Buen Vivir* (CIBVs) offer child care services through a community-based program. They serve the children of working mothers and seek to provide early stimulation, nutrition and child care, thus enabling mothers to work. The program has 3,800 centers that operate eight hours a day, and it serves 138,117 children under the age of 5. The program is active in 855 urban and 527 rural communities. The large majority of centers operate under an agreement made between INFA and local governments or civil society organizations. CIBVs are staffed by community mothers.

The program *Creciendo con Nuestros Hijos* (CNH) is a parenting program focused on mothers who do not work. The program has 907 points of service, 580 of which are rural. It serves 356,416 families. The program combines weekly four-hour group sessions for older children with weekly

Table 51. Overview of major public child development programs visited in Ecuador.

Institution	Institute for Children and Families	
Program	**Centros Infantiles del Buen Vivir**	**Creciendo con Nuestros Hijos**
Children served (2011)	138,117	356,416
Age group served	0 to 60 months	0 to 60 months
Centers in operation (2011)	3,800	907 agreed meeting centers
Staff (2011)	23,965	6,055
Operating schedule	12 months per year 5 days per week 8 hours per day	12 months per year 1 day per week 4 hours per group visit/1 hour per individual visit
Geographic coverage	855 communities/527 of which are rural	907 communities/580 of which are rural
Target population	- Low-income families at social risk - Working mothers	- Low-income families at social risk - Non-working mothers
Targeting method	Availability of the service in the area.	Availability of the service in the area.

Source and preparation: the authors.

one-hour home visits for the youngest children. Assignment to one program or the other (CNH or CIBV) depends on demand and the mother's employment status. If she works, she can send her children to a CIBV, but if she is not working, she can participate in the CNH program. The CNH is considered a more viable program type for geographically disperse communities.

The CIBVs manage a budget of US$129 million annually, while the CNH, serving a population almost three times greater, has a budget of US$107.6 million. Although the main expenditure categories are the same for both types of programs (infrastructure and salaries), it is notable that the CIBVs spend much more on salaries (45% vs. 26%), due to higher staffing requirements. It is worth mentioning that the cost of upgrading the facilities where CNH sessions are conducted accounts for a large percentage of their expenses (60%). The CIBVs operate mainly through agreements with third parties (local governments, community organizations, churches, NGOs, etc.) that are in charge of providing services. In return, they receive a monthly payment proportional to the number of children served to cover food expenses and staff salaries. The annual cost per child for the CIBVs is US$935, while it is US$302 for the CNH. This gap is even greater if one takes into account the difference in frequency and intensity among the programs. Neither program

Table 52. Income and expenditures of major public child development programs visited in Ecuador.

Institution	Institute for Children and Families	
Program	**Centros Infantiles del Buen Vivir**	**Creciendo con Nuestros Hijos**
Total expenditures (2010)	US$130,514,749.1	US$107,658,063.7
Materials	2.1%	3.3%
Food	1.4%	10.9%
Wages	44.6%	25.6%
Infrastructure/Maintenance	50.8%	59.6%
Training	1.1%	0.7%
Annual cost per child (2010)	US$935.5	US$302.1
Total income (2010)	US$129,210,656.4	US$107,658,063.7
Fees paid by families	No payment required, although it is common practice for centers to charge a monthly contribution of up to US$10.	No payment required.

Source and preparation: the authors.

Table 53. Components of major public child development programs visited in Ecuador.

Institution	Institute for Children and Families	
Program	**Centros Infantiles del Buen Vivir**	**Creciendo con Nuestros Hijos**
Components		
Child care services	Center-based child care for working mothers	No child care service provided.
Food services	2 meals and 2 snacks per day.	They provide a snack during sessions. Nutrition is discussed with parents during sessions.
Nutritional monitoring	Height and weight are measured at the centers with a highly variable frequency.	Height and weight are measured at the centers with a highly variable frequency.
Provision of supplements	Sprinkles are provided daily.	No supplements provided.
Parental support	Individual meetings held at infrequent and variable intervals to discuss the children's progress.	Central focus of the program. Weekly sessions with parents and children. One 4-hour session or two 2-hour sessions are conducted, depending on the age of the child. Individual sessions may also be conducted with those living in sparsely populated rural areas.

Source and preparation: the authors.

requires parents to make a copayment in order to receive services. However, in practice, CIBVs often charge the families who use this service a monthly contribution fee. This was verified during visits to the centers of this program.

The CIBVs provide two meals and two snacks a day. Additionally, the program adds micronutrients (sprinkles) to the food served to the children. Children are weighed and measured with a frequency that depends on their age. The CNH program provides a snack during sessions. Anthropometric monitoring is similar to that of the CIBVs, although neither micronutrients nor supplements are given.

Work with the parents at CIBVs is done through individual meetings held on a variable, infrequent basis, where the children's progress is discussed. At the CNH program, work with parents constitutes the main component. Parents participate with their children in weekly sessions, they receive nutritional information concerning the development of their children, and they learn stimulation and play techniques.

Care at the CIBVs occurs mainly in establishments provided by the operators, and they frequently use facilities attached to schools or churches. The centers meet minimum space requirements per child, and they have basic quality standards, especially with regard to health and safety. The CNH program operates out of modified community centers or family homes.

During the 2011 interview with this program, it was reported that the CIBVs employed two types of personnel. Coordinators must have a degree in early childhood care or education and two years of experience. The community workers, who deal directly with the children, must have completed primary school and a minimum of one year of experience. CNH community workers or home visitors must have a high school diploma with a concentration in education or training at a university and one year of experience in child development.

CIBV community workers receive compensation of US$200 per month and coordinators receive US$220, while CNH community workers earn US$370. They have no employment relationship with INFA nor do they participate in the social security system. Child-to-caregiver ratios at the CIBVs are 6.8 children per adult for ages 0 to 2 and 8.2 children for ages 2 to 6. CNH works with groups of up to 12 parents per session.
It is worth highlighting that in the months following the completion of this interview with INFA, the Government of Ecuador has

Table 54. Infrastructure and human capital of major public child development programs visited in Ecuador.

Institution	Institute for Children and Families	
Program	**Centros Infantiles del Buen Vivir**	**Creciendo con Nuestros Hijos**
Quality		
Site where program operates	- Program centers - Facilities attached to a church or school - Community centers	- Community centers - Modified family homes
Standards	Information on the quality of the infrastructure is collected, but standards have not been identified.	No standards for the quality of the spaces or facilities where the sessions are conducted.
Staff profile	Coordinators: a certificate or professional degree in child care or education. 2 years of experience.	Community workers: high school degree with a concentration in teaching or university training, preferably in the social sector. 1 year of experience in child development, preferably with experience in community projects.
	Community workers: must have completed 7th grade (finished elementary school). 1 year of experience and an area native.	
Child-to-caregiver ratios (number of children per adult)	6.79 for ages 0 to 2 8.18 for ages 2 to 6	12.0 parents per session
Monthly compensation	US$220.0 for coordinators US$200.0 for community workers	US$370.0 for community workers

Source and preparation: the authors.

undertaken major reforms in the services studied. One of those reforms includes hiring a professional for each of the CIBV establishments. Although it was reported during the 2011 interview conducted with this program that coordinators were required to have completed tertiary education, this was not enforced. Beginning in April 2012, a large amount of effort was invested in recruiting, hiring, and training coordinators who would meet this profile. Moreover, their salaries were increased significantly (to US$700 per month, plus benefits). This effort is part of a more ambitious strategy that seeks reform in the quality of these services and that entails a political and budgetary commitment of considerable magnitude.

4.8 El Salvador

ISNA (Salvadoran Institute for the Comprehensive Development of Children and Adolescents) is responsible for the public provision of early childhood services. The program offers care through two services, the *Centros de Bienestar Infantil* (CBIs) and *Centros de Desarrollo Infantil* (CDIs), created in 1993. Although ISNA has nationwide coverage, it only serves 5,463 children in 204 centers, mainly due to budgetary constraints. The target population is children between the ages of 7 and 72 months from low-income families. The service targets its beneficiaries based on center location.

The program has a budget of US$2.7 million a year, and parents make a voluntary contribution of 75 cents a day. The program's main expenses are food (47%) and wages (44%). The annual cost per child is US$504.

The program's infrastructure spending is low due to the use of old facilities

Table 55. Overview of major public child development programs visited in El Salvador.

Institution	Salvadoran Institute for the Comprehensive Development of Children and Adolescents
Program	**Centros de Bienestar Infantil (CBI) and Centros de Desarrollo Integral (CDI)**
Children served (2011)	5,463
Age group served	7 to 72 months
Centers in operation (2011)	204
Staff (2011)	643
Operating schedule	12 months per year CBI: 5 days per week, 8 hours per day CDI: 5 days per week, 10.5 hours per day
Geographic coverage	Nationwide coverage
Target population	Low-income population
Targeting method	The location of centers is used for targeting.

Source and preparation: the authors.

Table 56. Income and expenditures of major public child development programs visited in El Salvador.

Institution	Salvadoran Institute for the Comprehensive Development of Children and Adolescents
Program	**Centros de Bienestar Infantil (CBI) and Centros de Desarrollo Integral (CDI)**
Total expenditures (2010)	US$2,725,711.4
Wages	45.0%
Training	1.3%
Administrative expenses	6.6%
Food	47.1%
Annual cost per child (2010)	US$504.1
Total income (2010)	US$2,753,711.4
Fees paid by families	Parents make a voluntary contribution of US$0.75 per day. Revenue from this source is primarily used to cover administrative expenses.

Source and preparation: the authors.

with little maintenance, and no new centers have been built in recent years. However, there are differences between the two types of services. CDI has better quality infrastructure, and it separates children into groups according to their ages. CBI, which is presented as a low-cost alternative, uses old facilities in fair condition, and it does not separate children into age groups. CDIs generally operate out of centers exclusive to the program, while CBIs are located in community centers or facilities attached to schools and churches. The program has not developed a set of standards, but it is believed that there are still some deficits, especially in health and safety issues.

In both cases, the centers provide breakfast and lunch. The CDIs provide two snacks while the CBIs offer just one, but both seek to cover 90% of daily caloric requirements. Children are weighed and measured monthly at the centers, a task that teachers are trained to perform. The information is systematized and analyzed later using growth charts. Neither nutritional supplements nor fortified foods are provided. The program has a parenting school that operates on

Table 57. Components of major public child development programs visited in El Salvador.

Institution	Salvadoran Institute for the Comprehensive Development of Children and Adolescents
Program	**Centros de Bienestar Infantil (CBI) and Centros de Desarrollo Integral (CDI)**
Components	
Child care services	CDIs: are higher-quality centers, with a monitored child-to-caregiver ratio and a longer day. They serve children from 6 months to 7 years of age. CBIs: are a lower-cost alternative. They serve children age 2 and up.
Food services	CDI: they provide breakfast, lunch and 2 snacks. CBI: they provide breakfast, lunch and one snack. They provide 90% of daily caloric needs.
Nutritional monitoring	Children are weighed and measured at the centers. Teachers are trained in this task. The information is recorded in a computerized system. Information is analyzed according to growth charts.
Provision of supplements	No supplements provided.
Parental support	A parenting school is held that addresses the topics of nutrition, alternative discipline and childrearing practices. The school is held monthly at CDIs and bimonthly at CBIs.

Source and preparation: the authors.

Table 58. Infrastructure and human capital of major public child development programs visited in El Salvador

Institution	Salvadoran Institute for the Comprehensive Development of Children and Adolescents
Program	**Centros de Bienestar Infantil (CBI) and Centros de Desarrollo Integral (CDI)**
Quality	
Site where program operates	- Centers exclusive to the program - Facilities attached to a church or school - Modified homes - Community centers
Standards	There is no information on compliance with space regulations. Regulations regarding staff have 50% compliance, and health and safety regulations have a lower compliance. Centers are rarely inspected.
Standards	CDI teachers: formally hired, with no minimum profile. The program invests in training. Position requires empathy with the children and community recognition.
	CBI mother caregivers: volunteers with no minimum profile. The program invests in training. Volunteer mothers quit their positions quite often once they obtain a certificate of some sort.
Child-to-caregiver ratios (number of children per adult)	5.0 for ages 0.5 to 2 7.5 for ages 2 to 7
Monthly compensation	US$402.0 for teachers US$68.6 for caregivers

Source and preparation: the authors.

a monthly basis at the CDIs and twice-monthly at the CBIs.

CDI teachers are formally hired, although no minimum level of education is required. Teachers earn a monthly salary of US$402. CBIs are staffed by community volunteer mothers. Some may have training in early childhood care, but there is no minimum educational requirement for the position. Community mothers receive a monthly stipend of US$68. Child-to-caregiver ratios are five children per adult for ages 0 to 2 and 7.5 per adult for ages 2 to 6 for both programs.

4.9 Guatemala

Both Guatemalan programs in this study provide center-based child care services.

The *Hogares Comunitarios* program falls under the First Lady's Secretariat of Social Work (SOSEP). Created in 1998 as a pilot program and based on a community model, it serves 16,143 children in 818 homes across the country. It covers 210 communities, 150 of which are rural. The program serves children under 6 from families in situations of poverty and social risk, prioritizing cases of malnutrition and working mothers. The target population is identified through home visits and verification of family income.

The *Programa de Atención Integral a la Niñez* (PAIN) initiative, under the Ministry of Education's Directorate-General of Education Quality Management (DIGECADE), operates in 122 rural and marginal urban communities in Guatemala, serving 23,269 children under age 6. The target population is low-income families at social risk. Targeting is based on the location of the centers.

While both programs are free to beneficiaries, they have very different budgets. The *Hogares Comunitarios* program receives US$9.3 million, with food as its main expenditure. Wages do not represent a significant expense since the staff in charge of children consists of unpaid volunteers. PAIN's annual budget is US$3 million and smaller than that of *Hogares Comunitarios* despite serving a larger population. All of the budgetary resources are allocated to the payment of salaries. Not much information on disaggregated expenditures could be obtained. The annual cost per child is US$574 for *Hogares Comunitarios* and US$128.6 for PAIN, one of the lowest among child care services in the region. *Hogares Comunitarios* offers seven different types of care depending on the number of children enrolled. Children are only organized by age when the groups are large. *Hogares Comunitarios* offers two

Table 59. Overview of major public child development programs visited in Guatemala.

Institution	Secretariat of Social Work of the First Lady	Directorate-General of Quality Management of the Ministry of Education
Program	**Hogares Comunitarios**	**PAIN**
Children served (2011)	16,143	23,269
Age group served	0 to 72 months	0 to 72 months
Centers in operation (2011)	818	420
Staff (2011)	1,560	754
Operating schedule	11 months per year 5 days per week 10 hours per day	10 months per year Ages 0-3: 1 day; ages 4-6: 4 days. Ages 0-3: 1 hour per day; ages 4-6: 3 hours per day
Geographic coverage	210 communities/150 of which are rural	122 rural and marginal urban communities
Target population	- Low-income population at social risk - Children suffering from malnutrition - Working mothers	- Low-income population at social risk - Rural and marginal urban populations
Targeting method	Targeting based on income statement and home visits.	Geographic targeting.

Source and preparation: the authors.

meals and two snacks a day. Children are measured and weighed every three months, and they receive micronutrient sprinkles and fluoride in coordination with health centers. Alternatively, PAIN provides services to children between the ages of 4 and 6, during three-hour sessions, four days a week. Children under 3 are seen in weekly hour-long sessions together with their mothers. PAIN centers do not offer food, monitor growth or provide nutritional supplements.

Hogares Comunitarios conducts twice-monthly workshops with parents, without children present, where child rearing, health and nutrition issues are discussed. PAIN centers offer monthly workshops that address similar issues. They also provide support for pregnant and nursing mothers.

Both *Hogares Comunitarios* and PAIN operate primarily in modified family homes, although some function in centers exclusive to the program or community centers. SOSEP reports good compliance with the standards established for community homes, but they do not have detailed information. Few centers have space for outdoor activities. PAIN does not possess quality standards, and it only oversees health and safety matters when a center first opens.

SOSEP specifies three staff profiles. Teachers must be pre-primary educators (a degree that requires nine years of

Table 60. Income and expenditures of major public child development programs visited in Guatemala.

Institution	Secretariat of Social Work of the First Lady	Directorate-General of Quality Management of the Ministry of Education
Program	**Hogares Comunitarios**	**PAIN**
Total expenditures (2010)	US$9,268,372.3	US$2,985,360.2
Administrative expenses	11.9%	0.0%
Food	87.6%	0.0%
Wages	0.0%	95.9%
Food	0.0%	4.1%
Annual cost per child (2010)	US$574.1	US$128.6
Total income (2010)	US$9,268,372.3	US$2,992,063.2
Fees paid by families	No payment required.	No payment required.

The exchange rate used was the average from December 2010: 7.98 quetzales per US dollar.
Source and preparation: the authors.

Table 61. Components of major public child development programs visited in Guatemala.

Institution	Secretariat of Social Work of the First Lady	Directorate-General of Quality Management of the Ministry of Education
Program	**Hogares Comunitarios**	**PAIN**
	Components	
Child care services	Different forms of care depending on the number of children at the center. Smaller groups without separation by age.	Center-based care for ages 4 to 6, 3 hours per day. Children ages 0 to 3 receive weekly 1-hour sessions with their mothers.
Food services	2 meals and 2 snacks per day No defined percentage of calories to cover per day.	The center does not offer food service. Nutrition is discussed with parents during monthly sessions.
Nutritional monitoring	Height and weight are measured every 3 months.	There is no nutritional monitoring.
Provision of supplements	Sprinkles and fluoride in coordination with health center.	No supplements provided.
Parental support	Bimonthly meetings with parents, without the child present. Childrearing, health, and nutrition issues are discussed.	Monthly workshops. Topics include childrearing, affection, nutrition and health. Care for pregnant and lactating mothers.

Source and preparation: the authors.

Table 62. Infrastructure and human capital of major public child development programs visited in Guatemala.

Institution	Secretariat of Social Work of the First Lady	Directorate-General of Quality Management of the Ministry of Education
Program	**Hogares Comunitarios**	**PAIN**
	Quality	
Site where program operates	- Modified family homes - Centers exclusive to the program - Community centers	- Modified family homes - Facilities attached to a church or school - Community centers
Standards	Centers mostly meet quality standards. Compliance with the size of care spaces is unknown. Few centers have space for outdoor activities. Bimonthly monitoring of the centers.	Basic quality standards. Program reports compliance close to 90%. The program only oversees health and safety matters when a center first opens. No standard for minimum space per child.
Staff profile	Teachers: certificate in pre-primary education. 9 years of education plus 3 years with concentration in pre-primary education. No minimum experience required.	Teachers: certificate in pre-primary education. 9 years of education plus 3 years with concentration in pre-primary education. No minimum experience required.
	Mother caregiver (administrative): has completed at least 6th grade. An area native and, preferably, a mother. Manages the center's funds.	Volunteer mothers: sometimes a mother volunteer is available to work at the center. No profile requirements.
	Mother caregiver (direct care): has completed at least 6th grade. Area native. Receives orientation upon hiring.	
Child-to-caregiver ratios (number of children per adult)	6 for ages 0 to 6	20 for ages 0 to 4 40 for ages 4 to 6
Monthly compensation	US$275.8 for teachers US$175.5 for both types of caregivers	US$470.1 for teachers US$0.0 for volunteer mothers

Source and preparation: the authors.

education plus three years of technical training), and they receive a salary of US$276 a month. There are two categories of "mother caregivers." The first type must have completed elementary school, and they tend to be in charge of to administrative tasks at the centers. The other type of mother caregiver works directly with the children. She must have completed elementary school, and she receives training before starting the job.

Both types of community mothers are paid a salary of US$175.5 a month. PAIN manages two different profile types: teachers—just like those at *Hogares Comunitarios*—must have a degree in pre-primary education, and volunteer mothers, who play the role of aides during the sessions and are not required to have a minimum educational level. Volunteer mothers receive no payment, but teachers are paid US$475.5 a month. SOSEP reports child-to-caregiver ratios of 6 children per adult for ages 0 to 6, and at PAIN, the ratios are 20 children per adult for ages 0 to 4 and 40 for ages 4 to 6. These ratios rank among the highest in the region.

4.10 Honduras

The study visited two programs in Honduras—one child care service and one nutrition program. The latter does not fit either of the two main program profiles covered by this analysis.

The *Bienestar Familiar y Desarrollo Comunitario* program of the Honduran Institute for Children and Families (IHNFA), founded in 1997, is a child care service with low national coverage. The program has 37 centers, which serve 1,848 children under the age of 6. The target populations are low-income families, malnourished children, families living at social risk, and the children of working mothers. The prioritization of slots occurs through a family needs assessment worksheet.

The *Programa de Atención Integral a la Primera Infancia* (PAIN) initiative of the Ministry of Health is a nutrition program, created in 1998. It works with families for three hours per month. Sessions are structured as a medical consultation

with a parental support component. The program has a completely rural focus, serving six of the country's 18 departments with coverage of 28,588 families. The target population consists of children under 4 living in poverty, service need or suffering from malnutrition, and the program targets beneficiaries at the local level.

The service provided by PAIN is free, unlike IHNFA's service, for which parents pay a fee of between US$1 and US$2.6 per month. IHNFA's annual budget is US$2.9 million, with an annual cost per child of US$1,584.

IHNFA has some higher-quality pilot centers, but overall, the service is provided in very basic facilities. The centers are open from 8 to 10 hours a day, five days a week, and they provide breakfast, lunch and two snacks. IHNFA takes anthropometric measurements of the children on a twice-yearly basis. This information is analyzed in order to coordinate the provision of nutritional supplements. The program distributes vitamin A, zinc, iron, folic acid, and deworming medicine twice yearly. Interaction with parents at IHNFA occurs through monthly talks, which address child rearing, health, nutrition and learning issues. PAIN measures and weighs the children at each monthly consultation, and according to the results, advises the parents regarding the care of their children. Zinc, iron and folic acid are provided twice yearly.

IHNFA centers generally operate out of facilities exclusive to the program, but they also use modified family homes. The program reports few quality standards, and the existing ones have a very low compliance rate (40%). There is also nothing in the way of systematic monitoring.

IHNFA centers employ teachers and caregivers. The teachers manage the centers and coordinate activities. In urban areas, they must have a university degree while in rural areas, a high school diploma is sufficient. They receive a monthly salary of US$399. Caregivers must have completed primary school, and they are in charge of providing direct care to the children. They receive a monthly salary of US$335. PAIN manages three staff profiles. Supervisors, who earn a salary of US$957, must have a health-related university degree and three years' experience in community projects. Community workers, earning a salary of US$478 a month, must have a high school

Table 63. Overview of major public child development programs visited in Honduras.

Institution	**Honduran Institute for Children and Families**	**Secretariat of Health**
Program	**Bienestar Familiar y Desarrollo Comunitario**	**Programa de Atención Integral a la Primera Infancia**
Children served (2011)	1,848	28,588
Age group served	0 to 72 months	0 to 48 months
Centers in operation (2011)	37	N/A
Staff (2011)	130	3,100
Operating schedule	12 months per year 5 days per week 8 to 10.5 hours per day	12 months per year 1 day per month 3 hours per session
Geographic coverage	Low nationwide coverage	Covers 6 departments. 100% rural
Target population	- Low-income population - Malnutrition - Social risk - Working mothers	- Low-income population - Malnutrition - Rural sector
Targeting method	A needs assessment instrument is used.	Geographic targeting, identifying populations with high levels of need.
Total expenditures (2010)	US$2,961,912.3	N/A
Annual cost per child (2010)	US$1,602.8	
Fees paid by families	Parents pay between US$1.04 and US$2.62 per month.	No payment required.

The exchange rate used was the average from December 2010: 18.8 lempiras per US dollar.
Source and preparation: the authors.

Table 64. Components of major public child development programs visited in Honduras.

Institution	Honduran Institute for Children and Families	Secretariat of Health
Program	**Bienestar Familiar y Desarrollo Comunitario**	**Programa de Atención Integral a la Primera Infancia**
	Components	
Child care services	Child care centers. There are some high-quality pilot centers, but most are in basic condition.	No child care service provided.
Food services	The program provides breakfast, lunch and 2 snacks a day.	Food is not given at the consultations.
Nutritional monitoring	Health centers weigh and measure the children every six months. Information is stored and analyzed for the provision of supplements.	Children are weighed and measured monthly at the consultations. Counseling is provided to the parents, according to the results.
Provision of supplements	The program provides vitamin A, zinc, iron, folic acid, and deworming medicine twice yearly.	Zinc, iron and folic acid are provided twice yearly.
Parental support	Monthly talks are held at centers, where childrearing, health, nutrition and learning issues are discussed.	The focus of the program is working with parents and providing medical care for the child. Training is conducted on various topics, according to the child's condition.

Source and preparation: the authors.

Table 65. Infrastructure and human capital of major public child development programs visited in Honduras.

Institution	Honduran Institute for Children and Families	Secretariat of Health
Program	**Bienestar Familiar y Desarrollo Comunitario**	**Programa de Atención Integral a la Primera Infancia**
	Quality	
Site where program operates	- Centers exclusive to the program. - Modified homes.	Sessions may be held in any environment.
Standards	There are no regulations in terms of minimum space requirements per child. Regulatory compliance is achieved at about 40% of the centers. Monitoring occurs infrequently.	There are no regulations governing the sites where sessions are held.
Staff profile	Teachers: they must have a university degree for centers in urban areas and a high school diploma for centers in rural areas. No previous/minimum experience required. They manage the centers and coordinate activities.	Supervisors: they must hold a university degree related to health and have 3 years of experience in community work.
	Caregivers: they must have completed elementary school. They are in charge of providing direct care to the children.	Community workers: they must have a high school diploma, preferably with a technical concentration in the medical field. No previous/minimum experience required.
		Volunteers: they must be literate. They are selected by the community.
Child-to-caregiver ratios (number of children per adult)	10.0 for ages 0 to 2 12.5 for ages 2 to 6	7.70 for ages 0 to 2
Compensación mensual	US$398.9 for teachers US$335.1 for caregivers	US$957.4 for supervisors US$478.2 for community workers US$0.0 for volunteers

Source and preparation: the authors.

diploma, preferably with a technical concentration in the medical field. Lastly, volunteers must only be able to read and write and are selected by the community.

At IHNFA, child-to-caregiver ratios are 10 children per adult for ages 0 to 2 and 12.5 children per adult for ages 2 to 6. PAIN conducts sessions with an average

of 7.7 families per community worker/ supervisor/volunteer.

4.11 Jamaica

The situation of the public supply of early childhood services in Jamaica is unique and differs in many ways from the rest of Latin America. There are two initiatives included in the study.

The first institution is the Early Childhood Commission of the Ministry of Education, established in 2003, which serves as a regulatory body for public and private early childhood services in Jamaica. The Commission regulates *Daycares* (ages 0 to 3, private), *Infant Schools* and *Infant Departments* (ages 3 to 5, public), *Basic Schools* (ages 3 to 5, private with public support), and *Prep Schools* (ages 3 to 5, private), which together serve a total of 132,000 children. Service coverage for children ages 3 to 5 is universal in Jamaica.

The second initiative is the *Roving Caregivers* (RC) program of the *Rural Family Support Organization* (RuFamSo), supported by UNICEF and the *Bernard van Leer Foundation*. Although this program operates without public funds, it was included in the study because this model is used in several Caribbean nations. The program began in 1996 as a training program for young people who had dropped out of school. It later became a pilot program that produced the first generation of caregivers. The RC model has been replicated in many parts of the Caribbean, being recognized as a low-cost alternative for providing parenting services to disperse populations. The program leverages the knowledge of mothers in the community and strengthens the links between them. The caregivers provide training to families on how to play with their children and how to develop their cognitive and psychosocial abilities. Currently, due to lack of funding, the project serves just 200 children under age 3 with a staff of 11 people. Sessions are held weekly, and the caregivers themselves, using their knowledge of the community, carry out the task of selecting beneficiaries.

Financial information is only available for the *Early Childhood Commission* (ECC), whose budget amounts to US$16.6 million a year. The main expenditure categories are salaries and training to support the centers' teachers. Financing from the ECC covers part of the operating costs of the centers. Families pay variable rates for the service, depending on the site, as they are not regulated by the Commission. The cost per child per year for the Commission is US$126, although this does not reflect the total cost of the service offered by the center.

The ECC establishes that centers must provide a minimum of 30% of children's daily caloric requirement, but each center can decide if it will cover a greater percentage. Additionally, there is no protocol governing the anthropometric

Table 66. Overview of major public child development programs visited in Jamaica.

Institution	Ministry of Education	Rural Family Support Organization
Program	**Early Childhood Commission**	**Roving Caregivers**
Children served (2011)	132,000	200
Age group served	0 to 60 months	0 to 36 months
Centers in operation (2011)	2,599	Home care
Staff (2011)	148*	11
Operating schedule	12 months per year 5 days per week 8 hours per day	12 months per year 1 day per week 1 hour per session
Geographic coverage	Nationwide coverage	3 rural locations in May Pen
Target population	- Universal for children ages 3 to 5	- Low-income population - Population with high social risk
Targeting method	It depends on the individual centers.	Performed locally. At-risk families are identified by workers.

*Staff only includes employees of the commission, not teachers and employees in the system.
Source and preparation: the authors.

Table 67. Income and expenditures of major public child development programs visited in Jamaica.

Institution	Ministry of Education	Rural Family Support Organization
Program	**Early Childhood Commission**	**Roving Caregivers**
Total expenditures (2010)	US$16,676,426.8	N/A
Materials	1.4%	
Administrative expenses	6.1%	
Wages	91.8%	
Infrastructure/Maintenance	0.5%	
Services	0.3%	
Annual cost per child (2010)	US$126.3	
Total income (2010)	US$16,676,426.8	
Fees paid by families	Parents pay varying fees. It depends on each center. Fees are unregulated.	No payment required.

The exchange rate used was the average from December 2010: 85.3 Jamaican dollars per US dollar.
Source and preparation: the authors.

Table 68. Components of major public child development programs visited in Jamaica.

Institution	Ministry of Education	Rural Family Support Organization
Program	**Early Childhood Commission**	**Roving Caregivers**
	Components	
Child care services	The Commission regulates early childhood centers in Jamaica. It regulates Daycares (ages 0 to 3, private), Infant Schools and Departments (ages 3 to 5, public), Basic Schools (ages 3 to 5, private with public support), and Prep Schools (ages 3 to 5, private). In Jamaica, there is no public support for care for children ages 0 to 3.	No child care service provided.
Food services	Regulations state that centers must at least provide lunch, meeting 30% of daily caloric needs.	No food provided.
Nutritional monitoring	Centers are responsible for monitoring. The information is not centralized.	Children's height is measured. This information is collected at varying intervals.
Provision of supplements	No supplements provided.	No supplements provided.
Parental support	Centers must conduct group sessions with parents where topics in nutrition, health, childrearing, care, and teaching and learning methods are discussed.	The program focuses on this aspect. Individual and group sessions are conducted where parents are taught to play with their children, take advantage of low-cost materials to make toys, and care for their children's hygiene, nutrition and health. An effort is made to always have the same home visitor facilitate the activities with parents.

Source and preparation: the authors.

monitoring of children. The RCs take anthropometric measurements with varying frequency, or they cull this information from medical reports. Neither of these services provides nutritional supplements.

Interactions with parents are regulated by the ECC, and the program requires that sessions be conducted with parents, where the issues of nutrition, health, child rearing, care, and teaching and learning methods are addressed. The RC program focuses on working with parents, and sessions, which may be group or individual, focus on teaching the parent how to play with the child, how to build toys from inexpensive materials, and

Table 69. Infrastructure and human capital of major public child development programs visited in Jamaica.

Institution	Ministry of Education	Rural Family Support Organization
Program	Early Childhood Commission	Roving Caregivers
	Quality	
Site where program operates	- Centers exclusive to the program - Facilities attached to a church or school	- Mainly in family homes
Standards	Special attention is paid to health and safety regulations. Although there are general rules regarding minimum space requirements and child-to-caregiver ratios, full compliance is not seen at many centers.	Due to the nature of the program, there is basic regulation and standards.
Staff profile	Teachers: they are categorized differently according to their level of training. On average, they have 12 years of education. They must have attended a teaching school, which provides different levels of study. They are encouraged to continue training while teaching at centers. They begin as teacher aides, and they are gradually promoted.	Caregivers: they must be mothers who were previously served by the program. No minimum education level or experience required
Child-to-caregiver ratios (number of children per adult)	5 for ages 0 to 1 7 for ages 1 to 2 8 for ages 2 to 4 10 for ages 4 to 6	5 for ages 0 to 1 7 for ages 1 to 2 8 for ages 2 to 4
Monthly compensation	US$187.5 per month for teachers as a support to the ECC at public centers. Private centers may pay different wages.	They receive a small stipend per month. They are not formal employees and only work part time.

Source and preparation: the authors.

how to develop good hygiene and health habits. The sessions take place once a week for an hour. An effort is made to always have the same home visitor or caregiver facilitate the sessions in order to develop rapport with families.

Jamaican centers generally have their own facilities, but sometimes they are attached to schools and churches. One of the main functions of the ECC is to monitor centers' compliance with health and safety measures, as well as quality standards in 12 areas, among those space and child-to-caregiver ratios. The standards in these last two areas are not met by many centers, and the ECC's efforts have been focused on solving these problems.

Teachers at the ECC centers are categorized differently depending on their level of training. The ECC and its centers encourage teachers to continue their studies while they work. In this manner, they may be promoted within the system. Salaries vary according to level of education, but on average, teachers earn a salary of US$187.5 a month. Alternatively, caregivers, who are volunteer mothers, are trained by the program before working with families. Training continues throughout the year. The position does not require a minimum level of education, and the caregivers receive a small monthly stipend for their services. The child-to-caregiver ratios at ECC centers range from 5 children per adult for ages 0 to 1, up to 10 children per adult for ages 4 to 6. The RCs must achieve these same ratios, although in practice, the two programs work with groups that exceed these figures.

4.12 Mexico

In Mexico, the directors of three programs were interviewed—two child care services and one parenting program. The first was *Programa Estancias Infantiles*, created in 2007 as part of the Secretariat of Social Development (SEDESOL). This program funds child care services for children 13 to 72 months old in 2,004 locations, with coverage totaling 266,406 children. Service is provided by private operators who must meet certain minimum standards to receive funding from SEDESOL for the operation of the daycare center. The subsidy offered by SEDESOL is supplemented by monthly payments made by parents. The program targets the children of working mothers or those seeking employment and single parents.

Families must demonstrate that their income is less than 1.5 times the minimum wage per month.

The daycare centers of the *Mexican Social Security Institute* (IMSS) were created in 1974, and they cover 205,203 children in 320 municipalities. The program provides child care services for individuals enrolled in the insurance system. This program has one of the largest budgets in Latin America, which allows it to maintain a very low child-to-caregiver ratio and to have excellent infrastructure.

PEI-CONAFE is a community-based parenting program that works with mothers or caregivers of children aged 0 to 48 months in 27,903 rural or marginal urban locations. It targets children without access to other child development services. This program, created in 1982 and retooled in 1994, serves 452,599 families through weekly sessions lasting two hours each, where a community facilitator trained by the program follows a curriculum based on four themes: child care and protection, personal and social development, language and communication, and exploration and knowledge of the environment.

The two child care services have nationwide coverage with similar dimensions, but CONAFE manages to cover twice the population. The scale of CONAFE represents a great effort considering that its target population is more disperse than that of the child care services.

In terms of costs, IMSS daycares have a budget that allows them to offer higher quality services with adequate regulation, infrastructure, materials and staff. The ratio of their total budget to the number of children they serve suggests that they spend US$3,104 per child annually. However, data from a recent IDB study reveals that this amount is larger in centers operated by IMSS than in those subcontracted to third parties (Myers et al., 2013).[19] SEDESOL's *Estancias* operate with a much more modest budget,

Table 70. Overview of major public child development programs visited in Mexico.

Institution	Secretariat of Social Development	Mexican Social Security Institute	National Council for Educational Development (CONAFE)
Program	**Programa de Estancias Infantiles para Apoyar a Madres Trabajadoras**	**Guarderías**	**Programa de Educación Inicial**
Children served (2011)	266,406	205,203	452,599
Age group served	13 to 72 months	0 to 66 months	0 to 48 months
Centers in operation (2011)	9,289	1,451	27,903
Staff (2011)	41,732	144,608	31,704
Operating schedule	12 months per year 5 days per week 8 hours per day	12 months per year 5 days per week 8 hours per day	9 months per year 1 session per week 2 hours per session
Geographic coverage	2,004 locales/524 of which are rural	320 municipalities/2 of which are rural	27,903 rural and marginal urban locales
Target population	- Low-income population - Working mothers	- Affiliated with Social Security - Working mothers	- Minorities and indigenous populations - Rural and marginal urban populations
Targeting method	Targeting based on income, geographic location and a socioeconomic characteristics questionnaire	The service is provided to affiliates of the Social Security system.	Geographic targeting, identifying populations with high levels of need

Source and preparation: the authors.

[19] Desarrollo Infantil Temprano en México: diagnóstico y recomendaciones, disponible en http://issuu.com/bid-sph/docs/resumen_desarrollo_infantil_en_mexico/1?viewMode=magazine&mode=embed

spending US$737 per child in 2010, plus a monthly copayment of US$29.4 made by the parents. In 2012, SEDESOL's daycare centers began implementing a new educational model focused on comprehensive care. The CONAFE program has a very low cost due to the type of intervention. It spends US$75 per child per year. It was not possible to obtain disaggregated data on expenses for SEDESOL and CONAFE.

Of the programs visited, the IMSS stands out, among other things, for the quality of its facilities and the way it provides health and nutrition services. At many of the daycare centers, health care is provided through a nurse's office with permanent staff. However, it is important to note that the quality of service is not homogeneous between the two forms of care used by the IMSS—direct provision and third-party providers. Subcontracted services tend to comply less rigorously with program standards.

Both child care services provide food (breakfast, lunch and snack), and they monitor the children's growth. None of the three programs provides nutritional supplements or fortified foods.

IMSS daycare centers stand out in the region for their emphasis on safety. All centers are equipped with fire extinguishers, alarms and special emergency equipment. In addition, weekly drills are performed and staff members are thoroughly prepared for emergencies. The directors report broad compliance with quality standards at their centers, particularly those providing direct services. SEDESOL daycares are mainly based in modified homes, hindering compliance with quality standards. Child-to-caregiver ratios at IMSS daycare centers are low, with 3.8 children per adult for ages 0 to 1, 5.1 for ages 1 to 2, 10.9 for ages 2 to 4, and 11.6 for ages 4 to 6. Curiously, the child-to-caregiver ratio at SEDESOL daycares is higher for the younger group of children, with eight children per adult for ages 0 to 4, and four children per adult for ages 4 to 6. With respect to the other parenting programs visited for this study, the ratio of parents to facilitators at CONAFE sessions is high, with 30 children per session. Sessions are often attended by a supervisor, who helps the facilitator. It is reported that sessions may lose some of their energy due to the presence of many children of different ages.

As for space standards, there is a notable difference between the minimum space required for SEDESOL's *Estancias* (two square meters per child) versus the minimum space necessary at IMSS daycares (four-and-a-half square meters).

Table 71. Income and expenditures of major public child development programs visited in Mexico.

Institution	Secretariat of Social Development	Mexican Social Security Institute	National Council for Educational Development (CONAFE)
Program	**Programa de Estancias Infantiles para Apoyar a Madres Trabajadoras**	**Guarderías**	**Programa de Educación Inicial**
Total expenditures (2010)	US$196,300,332.2	US$581,072,121.2	US$33,966,758.6
Administrative expenses	N/A	3.0%	N/A
Materials		0.0%	
Food		2.2%	
Wages		24.5%	
Infrastructure/Maintenance		1.9%	
Services		68.3%	
Training		0.0%	
Annual cost per child (2010)	US$737.4	US$3,104.2	US$75.0
Total income (2010)	US$196,439,598.6	US$636,991,804.4	US$33,966,758.6
Fees paid by families	Parents pay an average of US$29.4 per month.	No payment required	No payment required

The exchange rate used was the average from December 2010: 12.4 Mexican pesos per US dollar.
Source and preparation: the authors.

Table 72. Components of major public child development programs visited in Mexico.

Institution	Secretariat of Social Development	Mexican Social Security Institute	National Council for Educational Development (CONAFE)
Program	**Programa de Estancias Infantiles para Apoyar a Madres Trabajadoras**	**Guarderías**	**Programa de Educación Inicial**
Components			
Child care services	Center-based child care for children of working mothers. At the time of the study, child care service was provided without an educational component, but beginning in 2012, the program began using a comprehensive curriculum. A general check-up is performed each day when the child arrives at the center, during which abuse or illness is detected.	Comprehensive care at centers exclusive to the program. Health care is provided at centers through a nurse's office with permanent staff.	While the sessions are held with parents, an aide cares for and plays with the children.
Food services	The program provides breakfast, lunch and afternoon snack. A cookbook is provided to the daycare centers. No defined percentage of daily caloric needs.	The program provides breakfast, lunch, and morning and afternoon snack. Cookbooks are distributed to the centers. They provide between 90% and 100% of daily caloric needs.	Sometimes a snack is provided at sessions.
Nutritional monitoring	Some centers monitor the children's growth. It is performed with varying frequency.	Height and weight monitoring is performed depending on the age of the child. In the event of problems, follow-up is performed by the center's nursing staff.	Growth monitoring of the children is not performed.
Provision of supplements	No supplements provided.	No supplements provided.	No supplements provided.
Parental support	There is an administrative contact, which informs parents on a regular basis about their children's attendance, menus and program obligations.	Sessions are held monthly or bimonthly to discuss childrearing methods and to provide information on child development.	This is the central focus of the program. Sessions address the development of parents' childrearing skills and teach methods for working with children (games and activities). Sessions revolve around four themes: child care and protection, personal and social development, language and communication, and exploration and knowledge of the environment.

Source and preparation: the authors.

Lastly, the wages paid to staff at SEDESOL and IMSS are similar, between US$304 and US$325 per month for teachers and about US$180 per month for aides and caregivers. CONAFE only provides a stipend of US$70.5 per month as a transportation reimbursement to the facilitators, who have volunteer status (i.e., they have no employment relationship with the program).

Table 73. Infrastructure and human capital of major public child development programs visited in Mexico.

Institution	Secretariat of Social Development	Mexican Social Security Institute	National Council for Educational Development (CONAFE)
Program	**Programa de Estancias Infantiles para Apoyar a Madres Trabajadoras**	**Guarderías**	**Programa de Educación Inicial**
Quality			
Site where program operates	- Modified family homes - Facilities attached to a church or school - Community centers	- Centers exclusive to the program	- Modified homes - Schools or churches - Community centers
Standards	The minimum space requirement per child is 2 square meters. Broad compliance with regulations concerning staffing, furnishings and spaces. Bimonthly inspections and visits.	The minimum space requirement per child is 4.5 square meters. Broad compliance with regulations concerning staffing, furnishings and spaces. Frequent inspections and visits. Special emergency response.	No regulations concerning the spaces used during sessions. The facilitator is responsible for ensuring safety and comfort during sessions.
Staff profile	Director of the center: must have a high school diploma. No other requirement. Manages the center's operations and answers to SEDESOL.	Education coordinator: must be an educator, childcare officer, educational assistant, or have a certificate in childcare plus 2 years of experience. Handles all administrative aspects of the center and plans educational activities.	Facilitators or community workers: must be literate and of legal age. No prior experience is required.
	Assistants: there is no minimum educational requirement. Responsible for caring for the children.	Educators: must have a certificate in childcare plus 2 years of experience. They are in charge of planning, design and development of activities.	
		Educational assistants: must be an educational assistant or childcare officer. They are in charge of providing direct care to the children.	
Child-to-caregiver ratios (number of children per adult)	8.0 for ages 1 to 4 4.0 for ages 4 to 6	3.8 for ages 0 to 1 5.1 for ages 1 to 2 10.9 for ages 2 to 4 11.6 for ages 4 to 6	30.0 children per session
Monthly compensation	US$325.2 for directors US$184.4 for assistants	US$304.2 for coordinators US$190.1 for educators US$190.1 for educational assistants	US$70.5 for community workers

Source and preparation: the authors.

4.13 Nicaragua

At the time the data for this study was collected, the main service provider for public early childhood services in Nicaragua used to be the PAININ program of the *Ministry of Family, Adolescent, and Child* Services. The program began as an IDB project in 1996, with a service delivery system operated by NGOs that were subcontracted by the Ministry. In 2008, as a result of a government decision, the program's service delivery became the responsibility of the Ministry, and the service was no longer subcontracted to third parties.

Although the Program had a monitoring system, during this new phase, the service's quality monitoring processes were hindered. At the time of the visit conducted as part of this study, the Program served 72,607 children under the age of 6 at 1,194 centers across the country. The target population is families in poverty and children suffering from chronic malnutrition, with targeting based on the location of centers and an instrument that seeks to identify vulnerable children.

PAININ has a budget of US$5.6 million per year, most of which is spent on salaries, services and food (88.8%), followed by administrative expenses (3.3%). The annual cost per child is very low at just US$76.7. Services are completely free of charge for parents.

At its centers, PAININ works with children divided into age groups, and care is provided only three hours a day. In addition, program staff makes home visits as part of the service. The centers provide just one meal a day, a morning snack. The program collects anthropometric measurements on the children every three months at the centers. Moreover, it provides sprinkles as a nutritional supplement to children 6, 12 and 18 months of age, who are given a packet daily for two months in a row every six months. That is, an average of four months of sprinkles is provided per year to children between the ages of 6 and 24 months. The program works with parents on child rearing and nutrition issues in monthly sessions without the child present.

PAININ mainly operates out of modified family homes, but it also operates at community centers or facilities attached to a school or church. The standards set by the program are quite basic in relation to other countries. An infrastructure survey conducted in 2010 showed that more than 30% of the facilities had damaged ceilings, floors or walls. Based on these

Table 74. Overview of major public child development programs visited in Nicaragua.

Institution	Ministry of Family, Adolescent, and Child Services
Program	**PAININ**
Children served (2011)	72,607
Age group served	0 to 72 months
Centers in operation (2011)	1,194
Staff (2011)	7,222
Operating schedule	11 months per year 5 days per week 3 hours per day
Geographic coverage	66 municipalities nationwide, mostly rural
Target population	- Populations living in poverty - Children with chronic malnutrition
Targeting method	Targeting based on geographic location and child vulnerability scale.

Source and preparation: the authors.

Table 75. Income and expenditures of major public child development programs visited in Nicaragua.

Institution	Ministry of Family, Adolescent, and Child Services
Program	**PAININ**
Total expenditures (2010)	US$5,907,276.0
Administrative expenses	3.3%
Services	48.8%
Wages	21.7%
Food	17.6%
Materials	8.6%
Annual cost per child (2010)	US$76.7
Total income (2010)	US$5,567,622.0
Fees paid by families	No payment required.

The exchange rate used was the average from December 2010: 21.8 cordobas per US dollar.
Source and preparation: the authors.

results, some of the facilities are currently being repaired. For this study, an attempt was made to document the percentage of centers that comply with standards; however, it was not possible to obtain that information during the interview.

The Program has two types of staff. Educators must have completed primary school, and in most cases, they must have community service experience. They care mostly for children over 3. Volunteer mothers, with no educational or minimum experience requirement, tend to children under 3. Child-to-caregiver ratios vary between 3.5 children per adult for ages 0 to 1 up to 11.1 for ages 4 to 6. Educators receive a stipend of US$70 a month, and volunteer mothers are paid even less, US$10 monthly. The staff has no formal employment relationship with the program.

PAININ as a program is coming to an end; however, the network of educators and aides formed over the duration of the Program is being incorporated by the Ministry of Family and the Ministry of Education in order to implement Nicaragua's new National Policy on Early Childhood. Various modalities of care are in the process of being implemented under this policy. In urban centers, child care services will offer care through *Centros de Desarrollo Infantil*. A family-oriented community-based service for

Table 76. Components of major public child development programs visited in Nicaragua.

Institution	Ministry of Family, Adolescent, and Child Services
Program	**PAININ**
Components	
Child care services	Separation into sub-groups by age.
Food services	Snack at the daycare center, prepared at the center with basic grains provided by the program. The supplement covers between 29% and 38% of daily caloric needs.
Nutritional monitoring	Assessment of height, weight and developmental milestones every three months, in coordination with the Ministry of Health.
Provision of supplements	Packets with 5 micronutrients, daily dose to be administered according to the WHO standard—60-day cycles at 6, 12 and 18 months of age.
Parental support	Monthly workshops without the child present. Childrearing and nutrition issues are addressed.

Source and preparation: the authors.

Table 77. Infrastructure and human capital of major public child development programs visited in Nicaragua.

Institution	Ministry of Family, Adolescent, and Child Services
Program	**PAININ**
Quality	
Site where program operates	- Community centers (simple public facilities) - Classrooms attached to schools
Standards	Monitoring is focused on enrollment, attendance, and length of service; compliance with content standards (technical guide) is no longer tracked by system tools.
Staff profile	Educators (both center- and community-based): elementary education. Community service requirement.
	Volunteer mother: literate but no academic requirement (10% had no schooling).
Child-to-caregiver ratios (number of children per adult)	3.5 for ages 0 to 1 3.7 for ages 1 to 2 4.0 for ages 2 to 4 11.1 for ages 4 to 6
Monthly compensation	US$70.0 for educators US$10.0 for volunteer mothers

Source and preparation: the authors.

children under three is also anticipated (replacing PAININ's home visits and born of a campaign called *Amor para los Más Chiquitos*, which lent its name to the National Program). The program has been working on a number of activities aimed at improving the quality of its services, through investments in equipment and infrastructure, a new curriculum, and training of its staff (offering a Certificate in Early Childhood Development). In addition, work is being done to expand the coverage of formal and community-based preschools, complemented by a parenting service provided through home visits.

4.14 Panama

In Panama, two programs were visited that provide child care and stimulation. One of these programs is targeted at a very vulnerable population: children with special needs.

The Ministry of Social Development's *Centros de Orientación Infantil y Familiar* (COIFs) is one of the principal public early childhood programs in Panama. Created in 1980, the program has not grown nor has it had the funding necessary to expand its coverage since that time. It currently serves 3,653 children under the age of 5. The program operates in 100 communities, six of which are rural, for eight hours per day. The program seeks to target the poor and working mothers, although the process of allocating slots occurs on a first-come-first-serve basis according to the order that parents register their children. The COIFs also play a regulatory role with respect to Panama's private preschools.

The *Programa de Estimulación Precoz* of the Panamanian Institute for Special Needs (IPHE) is a program that specializes in caring for children with special needs. The program serves more than 67,501 children through medical consultations and another 1,642 through its stimulation rooms. The program targets beneficiaries based on the geographic location of its services, giving priority to the poorest areas.

IPHE has a budget of US$1.7 million a year, which is mainly used to pay staff salaries (92%). The stimulation rooms function thanks to cooperation with the COIF centers that house them, and doctor visits are not financially dependent on the program but instead on the health center where they are performed. This explains why the costs appear to be so low. As a result, the annual cost per child incurred by the program is only US$26. The COIF's budget is round US$1 million; of this amount, 75% has been invested in infrastructure, maintenance,

Table 78. Overview of major public child development programs visited in Panama.

Institution	Ministry of Social Development	Panamanian Institute for Special Needs
Program	**Centros de Orientación Infantil y Familiar**	**Programa de Estimulación Precoz**
Children served (2011)	3,653	67,501 (2010)
Center-based care (2010)	3,653	1,642
Age group served	0 to 60 months	0 to 72 months
Centers in operation (2011)	102	186*
Staff (2011)	337	164
Operating schedule	12 months per year 5 days per week 8 hours per day	12 months per year Under the age of 1, 30 min. per appointment Age 1 to 5, 4 hours per day, 5 days per week
Geographic coverage	100 communities/6 of which are rural	139 communities/46 of which are rural
Target population	- Low-income population - Working mothers	- Children with special needs - At-risk population
Targeting method	Slots awarded on a first-come-first-served basis	Geographic targeting, identifying populations with high levels of need

*Includes health centers, where most children are served, and rooms/child care centers.
Source and preparation: the authors.

and materials. IPHE services are free to families, and the program reports that it achieves 100% coverage of its target population. The COIFs charge parents between US$0.50 and US$20 per month, with an average fee of US$8.

The COIF program provides its service at its own centers, and it operates eight hours per day, 12 months per year. The program offers lunch and two snacks per day, but it has not defined what percentage of the daily caloric requirement should be covered. It also monitors the children's growth every three months, and iron supplements are provided as needed.

IPHE offers a stimulation service for four hours a day through special rooms at COIF centers or other public daycares for children over the age of 1. Care for children under the age of 1 occurs through medical consultations. Lunch and two

Table 79. Income and expenditures of major public child development programs visited in Panama.

Institution	Ministry of Social Development	Panamanian Institute for Special Needs
Program	**Centros de Orientación Infantil y Familiar**	**Programa de Estimulación Precoz**
Total expenditures (2010)	US$939,143.4	US$1,752,963.0
Administrative expenses	0.0%	1.6%
Materials	33.5%	4.0%
Food	10.2%	2.1%
Wages	14.3%	91.6%
Infrastructure/Maintenance	42.0%	0.4%
Training	0.0%	0.3%
Annual cost per child (2010)	US$257.1	US$ 25.9*
Total income (2010)	US$939,143.4	US$1,752,963.0
Fees paid by families	Parents pay between US$0.5 and US$20.0, with an average of US$8.0.	No payment required

*This value does not include the cost of attention at health care centers, which significantly lowers costs.
Source and preparation: the authors.

Table 80. Components of major public child development programs visited in Panama.

Institution	Ministry of Social Development	Panamanian Institute for Special Needs
Program	**Centros de Orientación Infantil y Familiar**	**Programa de Estimulación Precoz**
	Components	
Child care services	Center-based child care for working mothers.	Specialized interactions at dedicated program centers or special rooms at COIF centers. Two 4-hour sessions per day. Care for children under the age of 1 through medical consultations.
Food services	The program provides lunch and 2 snacks a day.	Lunch and 2 snacks are provided at centers. Food is not given at the consultations.
Nutritional monitoring	The teacher weighs and measures children every 3 months. The information is systematized, analyzed by nutritionists, and given to parents.	Children are weighed and measured three times per year. Data is stored and used to provide guidance to parents.
Provision of supplements	Iron given as necessary.	Deworming medicine is provided annually as well as fortified foods.
Parental support	Monthly talks are held at centers, without the child present, where childrearing, health, nutrition and learning issues are discussed.	Sessions are held monthly to help parents understand their role in the development of their child.

Source and preparation: the authors.

snacks are provided in these rooms. Anthropometric measurements are taken at the beginning, middle and end of the year, and the data is analyzed and shared with parents. Children receive deworming medication annually as well as fortified foods.

The COIFs hold monthly talks for parents that address child rearing, nutrition, health and learning issues. At IPHE, apart from medical consultations for children under 1, monthly sessions are held with parents to talk about their role in their child's development, with an emphasis on the needs of the child (Box 13 describes these spaces in greater detail).

The COIFs primarily work out of their own facilities, but they also use spaces attached to schools or churches. The centers have few regulations in terms of space, but they do meet minimum requirements regarding supplies of games and materials. The main IPHE points of service are health centers, but they also have centers for their exclusive use and rooms attached to COIF centers. In the case of both programs, the monitoring of centers occurs infrequently and even less often in rural areas.

The COIFs have two staff profiles: teachers and teaching assistants. According to program staff, minimum educational requirements are not being met and a pay scale has not been defined for the centers' teachers.

IPHE maintains a group of employees with excellent professional backgrounds, due to the importance of specialized training (speech therapists, physical therapists) to serve children with special needs. These staff members work as a team, traveling between centers, with support from educators and permanent aides. The support staff is less specialized. Aides are

Table 81. Infrastructure and human capital of major public child development programs visited in Panama.

Institution	**Ministry of Social Development**	**Panamanian Institute for Special Needs**
Program	**Centros de Orientación Infantil y Familiar**	**Programa de Estimulación Precoz**
	Quality	
Site where program operates	- Centers exclusive to the program - Facilities attached to a church or school - Community centers	- Health centers - Centers exclusive to the program - Rooms attached to COIF centers
Standards	There are no regulations in terms of minimum space requirements per child. Regulations are met in terms of furnishings and staffing. There is no compliance with standards regarding outdoor areas and play spaces.	There are no regulations in terms of minimum space requirements per child. Standards lacking in terms of furnishings and outdoor spaces Monitoring of centers every 4 months.
Staff profile	Teachers: the minimum professional profile for hiring is not met due to staffing problems. On average, teachers have 3 years of post-secondary education.	Stimulation specialists: must hold a degree in special education. They work in traveling groups.
	Teacher aides: on average, they have not completed high school.	Educators: 3 years of technical education or a degree in special education.
		Aides: no minimum professional profile required. Persons with disabilities are sought for the positions.
Child-to-caregiver ratios (number of children per adult)	3.5 for ages 0 to 1 4.5 for ages 1 to 6.8 for ages 2 to 4 25.0 for ages 4 to 6	12.0 for ages 0 to 1 7.5 for ages 1 to 4
Monthly compensation	N/A	US$700.0 for stimulation specialists US$560.0 for educators US$400.0 for aides

Source and preparation: the authors.

paid US$400 a month, educators US$560, and stimulation specialists US$700.

In the COIFs, child-to-caregiver ratios vary from 3.5 children per adult for children between the ages of 0 and 1, up to 25 for children between the ages of 4 and 6. For IPHE, the ratios are 12 children per physician at consultations for children under the age of 1, and 7.5 children per adult for all other ages in the stimulation rooms.

4.15 Paraguay

One of the most unusual programs in the region visited as part of this study is *Programa Nacional Abrazo* of the National Secretariat for Children and Adolescents (SNNA). Since its inception in 2005, the program has served as a safety net for street children and children who work in public places, ages 0 to 14, where they are given comprehensive care, and, in cases of extreme poverty, a subsidy for the child's family, in part to avoid child labor and to replace the income brought home by the child. Currently, the Program serves 2,700 children at its centers, 740 of whom are between the ages of 0 and 4 (53% of the children in the program are 0 to8 years old). Although the magnitude of attention is lower than that of other programs in the region, its target population makes this level of coverage significant. The program has a budget of US$6 million a year, with US$2,241 being invested per child per year to provide good quality care.

The program provides child care services in rooms divided by age groups (a two-year range in each). Breakfast, lunch and a snack are provided, but the percentage of the daily minimum caloric intake has not been defined. Anthropometric monitoring

Table 82. Overview of major public child development programs visited in Paraguay.

Institution	National Secretariat for Childhood and Adolescence
Program	**Programa Nacional Abrazo**
Children served (2011)	2,700, of which 740 are between 0 and 5 years.
Age group served	0 to 72 months (the age group selected for this study), although the program serves children up to age 14
Centers in operation (2011)	47
Staff (2011)	60
Operating schedule	12 months per year 6 days per week 15 hours per day
Geographic coverage	Nationwide coverage
Target population	Street children ages 0 to 14 with a family reference.
Targeting method	Geographic targeting, in areas with child labor. The program also uses the quality-of-life index; if family is extremely poor, they qualify to receive a subsidy that replaces the child's income
Total income (2010)	US$6,051,842.4
Annual cost per child (2010)	US$2,241.4
Fees paid by families	No payment required

The exchange rate used was the average from December 2010: 4,652.9 guaranies per US dollar.
Source and preparation: the authors.

Table 83. Components of major public child development programs visited in Paraguay.

Institution	National Secretariat for Childhood and Adolescence
Program	**Programa Nacional Abrazo**
Components	
Child care services	Care for street children. Rooms divided by age groups, with intervals of 24 months between groups.
Food services	Breakfast, lunch and snack are provided.
Nutritional monitoring	Height and weight monitoring performed every six months.
Parental support	Once children no longer receive services at the centers, monthly home visits are conducted by a team of highly trained professionals.

Source and preparation: the authors.

Table 84. Infrastructure and human capital of major public child development programs visited in Paraguay.

Institution	National Secretariat for Children and Adolescents
Program	**Programa Nacional Abrazo**
Quality	
Site where program operates	- Program centers - Community centers
Standards	Basic standards. Compliance with staffing and safety standards at centers is between 10% and 50%. Health regulations are well-monitored.
Staff profile	Preschool teachers: preschool teacher (3 years) plus 2 years (minimum) of specific experience with street children.
	Aides: students of preschool education.
	Family support: psychologist, social worker or students in their final years of study.
Child-to-caregiver ratios (number of children per adult)	1.9 for ages 0 to 1 4.4 for ages 1 to 6
Monthly compensation	US$419.7 for preschool teachers US$386.9 for aides US$644.8 for family support

Source and preparation: the authors.

is performed every six months, and nutritional supplements are not given.

In addition to child care services at the centers, *Programa Nacional Abrazo* has a special parenting component. Once children have completed their cycle in the program, continuous follow-up with the parents or primary caregivers is performed on a monthly basis, where issues related to care, teaching and learning methods, nutrition, health, and development are discussed. This particular component is an intervention with characteristics similar to parenting programs.

Services are provided in centers belonging to the program as well as community centers. The program is not particularly strong in terms of infrastructure quality, but it focuses on providing teachers with a good professional profile and having the longest hours of operation of all the programs considered—15 hours a day, six days a week. It seeks to provide a safe alternative to children who otherwise would spend a great deal of time out on the streets unsupervised.

Centers hire two types of staff. Teachers must possess a degree in early childhood education and two years of experience. Aides must be students studying early childhood education. They receive a monthly salary of US$419 and US$387, respectively. Psychologists, social workers, or students in their final years of study in one of these majors are sought to work with parents. Child-to-caregiver ratios are very good with 1.9 children per adult for ages 0 to 1 and 4.4 children per adult for ages 1 to 6.

4.16 Peru

The study included two public child care services in Peru, both belonging at the time of the visit to the Ministry of Women and Social Development.

Programa Nacional Wawa-Wasi, created in 1999 with funding from the IDB, serves 55,284 children between 6 and 48 months of age in 116 rural districts and 172 urban areas. The Program functions through management committees, made up of five members of the community who are elected at community assemblies. These committees sign a management agreement with the program, allowing them to operate their services. They receive funding from the Ministry, which they supplement with a voluntary co-pay from parents of US$4.50 per month, on average. Care is targeted at families in the three lowest income quintiles and children suffering from chronic malnutrition. Single mothers and large families also receive priority.

Following the interview conducted for this study, the Program underwent major reforms. First, in 2011 it was dissolved. Based on *Programa Nacional Wawa-Wasi,*

Table 85. Overview of major public child development programs visited in Peru.

Institution	Ministry of Women and Social Development	INABIF - Ministry of Women and Social Development
Program	**Wawa-Wasi**	**Centros de Desarrollo Integral de la Familia**
Children served (2011)	55,284	3,670
Age group served	6 to 48 months	6 to 72 months, adolescents, and the elderly
Centers in operation (2011)	7,089	36
Staff (2011)	12,125	261
Operating schedule	12 months per year 5 days per week 8 hours per day	12 months per year 5 days per week 8.5 hours per day
Geographic coverage	288 districts nationwide/116 rural and 172 urban	31 districts nationwide
Target population	- Children in the 3 lowest income quintiles - Children with chronic malnutrition - Children of single mothers and large families	- Populations in conditions of poverty and at risk
Targeting method	Targeting based on geographic location. The program also uses household survey that targets families based on the number of dependents	Targeting using socio-economic worksheet.

Source and preparation: the authors.

Table 86. Income and expenditures of major public child development programs visited in Peru.

Institution	Ministry of Women and Social Development	INABIF - Ministry of Women and Social Development
Program	**Wawa-Wasi**	**Centros de Desarrollo Integral de la Familia**
Total expenditures (2010)	US$25,843,449.4	US$8,004,556.5
Administrative expenses	5.8%	6.2%
Wages	52.0%	23.5%
Materials and services	48.0%	70.2%
Total income (2010)	US$25,849,282.9	US$9,329,589.0
Annual cost per child (2010)	US$467.6	US$753.9
Fees paid by families	Between US$1.9 and US$9.3/ month. Average of US$4.5/month.	Between US$0.0 and US$14.9/ month

The exchange rate used was the average from December 2010: 2.81 nuevos soles per US dollar.
Source and preparation: the authors.

Programa Nacional Cuna Más was created. *Cuna Más* offers two types of care—a daycare service and a parenting program. The daycare service has been placed in charge of managing *Wawa-Wasi's* services. *Cuna Más* forms part of the Ministry of Development and Social Inclusion (MIDIS). The Program is undergoing a series of transformations aimed at improving quality through investment in infrastructure and equipment, lower child-to-caregiver ratios, the introduction of a new educational model, staff training, and recruitment of a greater number of professionals for the support and mentoring of community mothers.

According to the decree establishing the new Program, its target population is limited to children under 36 months of age, their families and expectant mothers. In particular, daycare services provide care for children aged 3 to 36 months. However, under the standards of *Cuna Más,* children between the ages of 3 and 6 months will only be accepted at centers with a professional staff.

Centros de Desarrollo Integral de la Familia (CEDIFs) were created in 1978 in the city of Lima as community kitchens. They became a state-run program in 1981, and later they began to offer child care and

Table 87. Components of major public child development programs visited in Peru.

Institution	Ministry of Women and Social Development	INABIF - Ministry of Women and Social Development
Program	**Wawa-Wasi**	**Centros de Desarrollo Integral de la Familia**
Components		
Child care services	Daycare centers without separation by age. They have groups of 6 or 8 children of all ages, depending on whether it is a rural or urban location.	Infant and toddler room and preschool. Additionally, they have programs to help teens and productive projects for the elderly.
Food services	Lunch and 2 snacks during the day. They provide 70% of daily caloric needs.	They provide breakfast, lunch and 2 snacks, which correspond to 75% of daily caloric needs.
Nutritional monitoring	Children are weighed and measured every 3 months at health centers. The information is analyzed in order to make decisions about the child.	Children are weighed and measured at the centers every 6 months. In the event of a problem, the child is referred to the prevention unit.
Parental support	Weekly workshops and monthly work modules (parenting school).	Monthly informational, educational and counseling sessions. Nutritional booklets are provided.

Source and preparation: the authors.

Table 88. Infrastructure and human capital of major public child development programs visited in Peru.

Institution	Ministry of Women and Social Development	INABIF - Ministry of Women and Social Development
Program	**Wawa-Wasi**	**Centros de Desarrollo Integral de la Familia**
Quality		
Site where program operates	- Modified family homes - Some community centers	- Program centers - Community centers
Standards	Criteria and quality standards established by the program. Between 60% and 90% compliance.	The program has no quality standards.
Staff profile	Mother caregivers: no minimum level of education required. They are responsible for the care, hygiene, food and stimulation of the children. Training is provided before work begins.	Facilitators: high school diploma required.
Child-to-caregiver ratios (number of children per adult)	6 at rural sites (all ages) 8 at urban sites (all ages)	No child-to-caregiver ratio stipulated in the program regulations.
Monthly compensation	US$85.3 for caregivers US$106.6 for supervisors US$690.0 for field coordinators	US$99.5 for facilitators

Source and preparation: the authors.

other family services. The centers target the poorest segment of the population through socioeconomic data applied at each of the centers.

Wawa Wasi's coverage is considerably higher than that of CEDIF, with 7,089 centers in comparison to CEDIF's 36. Additionally, *Wawa Wasi* reaches 288 districts, both rural and urban, while CEDIFs are located in 31 marginal urban districts.

Interestingly, although *Wawa Wasi's* coverage is far superior to that of CEDIF, its budget is not. At *Wawa Wasi*, the main expenditure category is salaries followed by materials. CEDIF's main expenditures

occur in the categories of materials and services, followed by salaries. The costs per child served are US$789 for CEDIF and US$489 for *Wawa Wasi*.

Wawa Wasi employs a community-based modality. At *Wawa Wasi* homes, children are not separated according to age, although the Program establishes that there cannot be more than one child under the age of 1 in each group of eight children under the care of an adult. Both programs offer a food service that covers about 70% of the necessary daily caloric intake and 100% of protein requirements, but only *Wawa Wasi* provides deworming medication if necessary. Both programs weigh and measure the children, although this occurs less frequently at *Wawa Wasi*, and they use the information gathered to identify problems and provide nutritional support.

Wawa Wasi mainly operates out of modified homes, although it also has some community centers. These spaces are generally small, and the bathroom and kitchen facilities are often insufficient. Compliance with infrastructure standards, monitored by the program, hovers between 60% and 90%. CEDIF usually possesses large facilities that can accommodate all of the family services it provides. Usually, the infant and toddler room and preschool are found in separate buildings within the same CEDIF. The program has no standards on space, staffing, safety, or health to help ensure a minimum level of quality. Something similar occurs with child-to-caregiver ratios; *Wawa Wasi* works with six children per adult in rural areas and eight in urban areas, while CEDIF has no such parameters.

Teachers' salaries are similar between the two programs. *Wawa Wasi* caregivers, who work in a volunteer capacity, receive a small monthly stipend of US$85, and they have no employment relationship with the program. Supervisors receive US$107 per month and coordinators earn US$690. CEDIF's facilitators earn US$100. At the time of the visit, one of the most important challenges facing both programs was that they were in the midst of a fairly rapid decentralization process that had begun in 2011.

4.17 Dominican Republic

The study interviewed three early childhood programs in the Dominican Republic. All three provide child care services; none has large-scale coverage. Table 89 describes the main features of the programs.

Table 89. Overview of major public child development programs visited in the Dominican Republic.

Institution	Office of the First Lady	National Council for Children and Adolescents	Dominican Social Security Institute
Program	**Espacios de Esperanza**	**Programa de Atención Integral a la Primera Infancia**	**Administración de Estancias Infantiles Salud Segura**
Children served (2011)	1,440	10,275	6,640
Age group served	37 to 66 months	0 to 72 months	0 to 60 months
Centers in operation (2011)	48	52	107
Staff (2011)	187	1,512	1,350
Operating schedule	10 months per year 5 days per week 3.5 hours per day	12 months per year 5 days per week 9 hours per day	12 months per year 5 sessions per week 8 to 10 hours per day
Geographic coverage	43 locales/36 of which are rural	Present in 25 provinces	Nationwide coverage
Target population	- Low-income population - Single mothers - Vulnerability of rights	- Low-income population - Conditions of vulnerability	- Workers enrolled in the social security system - Income up to 3 times the minimum wage
Targeting method	A council within each center selects the families.	A multidisciplinary worksheet is used	Targeting by income. Must be enrolled in social security program

Source and preparation: the authors.

Espacios de Esperanza del Despacho de la Primera Dama, created in 2009, serves 1,440 children in 48 centers. The program provides care three-and-a-half hours per day, 10 months of the year. The main goal of this program is to provide a space where children can receive stimulation and have access to computers with Internet. In addition, the centers concern themselves with providing enjoyable spaces, children's books, and play materials. The target population consists of children between the ages of 3 and 5, families with limited resources, children of single mothers, and children whose rights are at risk. A council within each center selects who will fill available program slots.

The *Programa de Atención Integral a la Primera Infancia* of the National Council for Children and Adolescents (CONANI) began in 1980. It currently serves 10,275 children under 6 at 52 centers across the country. The centers operate nine hours a day throughout the entire year and serve vulnerable, low-income populations. The program targets beneficiaries using a multidisciplinary worksheet.

The *Administración de Estancias Infantiles Salud Segura* of the Dominican Social Security Institute (IDSS) is a program responsible for providing care to the children of workers enrolled in the social security system. Founded in 1990 as a pilot program for mothers working in a free trade zone, today it operates throughout the country, serving 6,640 children at 107 centers. Its target population consists of the children of social security enrollees whose income does not exceed more than three times the minimum wage.

In regard to financial aspects of the programs, Table 90 shows that *Espacios de Esperanza* and CONANI centers do not charge for their services, while centers belonging to *Estancias de la Seguridad Social* charge US$20.60 per month per child. CONANI has an annual budget of US$20.6 million, which it primarily invests in administrative costs (56%, which includes teacher salaries), followed by infrastructure (15%) and food (11%). IDSS spends US$5.6 million, with salaries (89%), materials (4%), and infrastructure (4%) as its main expenses. CONANI's annual cost per child is US$2,091, while the cost is substantially lower at IDSS centers, at US$531 per child per year. No financial information was obtained from *Espacios de Esperanza*.

In regards to the services provided by the programs, Table 91 details that *Espacios de Esperanza* are located in Community Technology Centers. While the community centers do have other functions, they

Table 90. Income and expenditures of major public child development programs visited in the Dominican Republic.

Institution	Office of the First Lady	National Council for Children and Adolescents	Dominican Social Security Institute
Program	**Espacios de Esperanza**	**Programa de Atención Integral a la Primera Infancia**	**Administración de Estancias Infantiles Salud Segura**
Total expenditures (2010)	N/A	US$20,567,263.5	US$5,587,634.1
Administrative expenses		56.0%	1.8%
Materials		7.2%	4.3%
Food		11.8%	0.3%
Wages		1.0%	88.9%
Infrastructure/Maintenance		15.0%	4.0%
Services		9.0%	0.6%
Annual cost per child (2010)		US$2,091.0	US$530.8
Total income (2010)		US$21,484,726.0	US$3,524,662.2
Fees paid by families	No payment required	No payment required	Families pay an average of US$20.6 per month.

The exchange rate used was the average from December 2010: 37.3 Dominican pesos per US dollar.
Source and preparation: the authors.

grant this program an area of exclusive use. Although the sessions are short, the centers are very well equipped, and computer access plays a central role in the stimulation services provided by the program. The program does not provide food, monitor growth or offer nutritional supplements. For its part, CONANI offers care at its own centers for nine hours a day, and it provides breakfast, lunch and two snacks during the day. The program does not have a defined minimum percentage for daily caloric intake with which it must comply. CONANI monitors growth on a monthly basis for children under the age of 1 and on a quarterly basis for children between the ages of 1 and 3. The information collected is systematized and analyzed according to development and growth charts. In addition, deworming medication and vitamin A are provided every six months. IDSS centers also offer a full day of care, and they provide breakfast, lunch and two snacks. The program aims to cover between 75% and 80% of daily caloric requirements,

Table 91. Components of major public child development programs visited in the Dominican Republic.

Institution	Office of the First Lady	National Council for Children and Adolescents	Dominican Social Security Institute
Program	**Espacios de Esperanza**	**Programa de Atención Integral a la Primera Infancia**	**Administración de Estancias Infantiles Salud Segura**
Components			
Child care services	Care provided during short sessions at well-equipped centers with computers, books and games. Rooms are found in Community Technology Centers (CTC).	Full-time day care at centers exclusive to the program. Centers with good infrastructure.	Full-time child care is offered.
Food services	There is no food service. There is a snack time, but children must bring their own lunch.	Breakfast, lunch and 2 snacks are provided. No defined percentage of daily caloric needs that the program must provide.	Breakfast, lunch and 2 snacks are provided. They provide between 75% and 80% of daily caloric needs.
Nutritional monitoring	Height and weight are not monitored.	Monthly height and weight monitoring for children under 1 and quarterly monitoring for children ages 1 to 3. Nutritional status is analyzed according to development and growth charts.	Growth monitoring is performed, and the information is analyzed for the implementation of food programs and supports. Monthly monitoring for children under 6 months, quarterly for ages 6 months to 1 year, and twice yearly thereafter.
Provision of supplements	No supplements provided.	Vitamin A and deworming medicine are provided every 6 months.	Vitamin A and deworming medicine provided every 6 months; iron, annually; folic acid, daily. Additionally, fortified food is provided.
Parental support	No work is done with the parents. Since sessions are so short, mothers are unable to work. The children's progress and development is reported to the mothers.	Frequent talks are held where nutrition and health promotion are discussed. Work is done with pregnant mothers on a monthly basis and quarterly sessions are held to discuss the importance of breastfeeding. A monthly parenting school is held where education and child abuse issues are addressed.	Bimonthly meetings with parents where topics of child care and best practices in childrearing, teaching and learning methods, health, nutrition, and development are discussed.

Source and preparation: the authors.

Table 92. Infrastructure and human capital of major public child development programs visited in the Dominican Republic.

Institution	Office of the First Lady	National Council for Children and Adolescents	Dominican Social Security Institute
Program	**Espacios de Esperanza**	**Programa de Atención Integral a la Primera Infancia**	**Administración de Estancias Infantiles Salud Segura**
Quality			
Site where program operates	- Dedicated rooms within Community Technology Centers (CTCs)	- Centers exclusive to the program	- Centers exclusive to the program - Modified homes - Facilities attached to churches or schools - Community centers
Standards	They meet all standards of staffing, space, safety and health. Bimonthly monitoring at centers. No defined minimum space requirement per child.	Minimum space requirement per child is 1 square meter. Broad compliance with regulations on staffing, furnishings and space—close to 90%. Quarterly inspections and visits.	The minimum space requirement per child is 1 square meter. Compliance with regulations on staffing, furnishings and space is close to 85%. Inspections and visits conducted every 4 months.
Staff profile	Teachers: a degree in early childhood education or a student in the final year. Good physical and mental health. An area native.	Teachers: degree in early childhood education. Responsible for the children's learning process.	Teachers: preschool educators; responsible for the implementation of lesson plans. They receive one month of training and must be area natives.
	Teacher aides: must be a senior at a public high school near the CTC.	Teacher aides: must be studying early childhood or basic education.	Assistants: must be studying early childhood or basic education. Area natives preferred. Provide support in carrying out the lesson plans and in child care.
		Educational coordinators: must have a degree in the field of education. They are in charge of the administrative tasks at the centers.	
Child-to-caregiver ratios (number of children per adult)	22.0 children, ages 2 to 6	3.9 for ages 0 to 2 7.6 for ages 2 to 6	3.0 for ages 0 to 2 7.5 for ages 2 to 4 10.0 for ages 4 to 6
Monthly compensation	US$321.7 for teachers US$53.6 for teacher aides	US$369.9 for teachers US$281.5 for teacher aides US$308.3 for educational coordinators	US$185.0 for teachers US$123.3 for assistants

Source and preparation: the authors.

and it monitors growth on a monthly basis for children under 6 months of age, on a quarterly basis for ages 6 to 12 months, and on a twice-yearly basis thereafter. IDSS centers provide fortified foods on a daily basis, together with folic acid. They also provide vitamin A and deworming medication every six months and iron once a year.

The *Espacios de Esperanza* program has no parenting activity that draws parents to the centers to work with them. The feeling is that mothers have limited availability to participate in these kinds of activities. CONANI holds very frequent meetings to talk about nutrition and health, and it runs a monthly parenting school to discuss educational issues and

child abuse. IDSS centers hold bimonthly meetings where they work with parents on issues of child rearing, teaching methods, health, nutrition and development. Regarding infrastructure quality, it was reported that standards compliance at *Espacios de Esperanza* is very good. In addition, bimonthly monitoring is performed at centers. However, when questioned about standards, it is notable that the program has not defined a minimum space requirement per child. CONANI designates a minimum of one square meter per child, and it reports compliance with this and other standards. Inspections and visits are conducted quarterly. IDSS operates out of dedicated centers, modified homes, facilities attached to schools or churches, and community centers. The program reports 85% compliance at centers in terms of space regulations (one square meter per child) and the provision of materials, with monitoring processes performed every four months.

Table 92 shows the characteristics of program staff. *Espacios de Esperanza* hires degreed teachers and teacher aides (students), who receive salaries of US$322 and US$54 per month, respectively. Child-to-caregiver ratios are high, with 22 children per adult for all ages. CONANI hires three types of staff: teachers (degreed, no experience required), teacher aides (students) and educational coordinators (degree in education, experience preferred). They earn salaries of US$370, US$282 and US$308 per month, respectively. On average, CONANI's child-to-caregiver ratios are fairly low, with 3.9 children per adult for ages 0 to 2 and 7.6 for ages 2 to 6. Lastly, IDSS hires teachers (preschool educators with one month of training) and assistants (students). Their salaries are US$185 and US$123, respectively. Child-to-caregiver ratios are similar to those of CONANI, with 3 children per adult for ages 0 to 2, 7.5 children per adult for ages 2 to 4, and 10 children per adult for ages 4 to 6.

4.18 Trinidad and Tobago

In Trinidad and Tobago, the provision of early childhood services occurs in partnership between the public and private sectors. In many aspects, these services operate with a structure similar to that of Jamaica. The *Early Childhood Care and Education Centers* (ECCE) of the Ministry of Education are governed by a Board, which also operates a few private centers. Table 93 shows that this service meets the needs of 3,413 children between the ages of 3 and 4, at 112 centers. Centers operate between four and eight hours a day, depending on the needs of the community. The program runs nine months out of the year, and it offers universal coverage without a specific targeting process.

The ECCEs have a budget of US$3.9 million annually, which is primarily spent on salaries (65%), followed by materials (27%) and services (6%). Parents are not required to make payments for services at centers. Table 94 also shows that the ECCE spends US$662 per child per year.

Regarding service components, all of the children are cared for in the same room, with no separation between age groups. This arrangement makes sense since it is a preschool service offered to children within a relatively narrow

Table 93. Overview of major public child development programs visited in Trinidad and Tobago.

Institution	Ministry of Education
Program	**Early Childhood Care and Education Centers**
Children served (2011)	3,413
Age group served	36 to 48 months
Centers in operation (2011)	112
Operating schedule	9 months per year 5 days per week 2 types of care, 8 hours per day and 4 hours per day
Geographic coverage	Nationwide coverage
Target population	Universal
Targeting method	No targeting processes.

Source and preparation: the authors.

Table 94. Overview of major public child development programs visited in Trinidad and Tobago.

Institution	Ministry of Education
Program	**Early Childhood Care and Education Centers**
Total expenditures (2010)	US$3,985,035.6
Materials	26.8%
Training	1.8%
Wages	65.3%
Services	6.0%
Annual cost per child (2010)	US$662.3
Total income (2010)	US$2,260,580.6
Fees paid by families	No payment required

The exchange rate used was the average from December 2010: 6.35 Trinidad and Tobago dollars per US dollar.
Source and preparation: the authors.

Table 95. Components of major public child development programs visited in Trinidad and Tobago.

Institution	Ministry of Education
Program	**Early Childhood Care and Education Centers**
Components	
Child care services	Children ages 3 to 5 in the same room, with 4-hour or 8-hour sessions.
Food services	Lunch is provided.
Nutritional monitoring	No growth monitoring performed
Provision of supplements	No supplements provided.
Parental support	Quarterly meetings are held with parents, and a communication log is maintained.

Source and preparation: the authors.

Table 96. Infrastructure and human capital of major public child development programs visited in Trinidad and Tobago.

Institution	Ministry of Education
Program	**Early Childhood Care and Education Centers**
Quality	
Site where program operates	- Centers exclusive to the program - Community centers
Standards	27% of the centers met the minimum space requirement. 92% compliance with health and safety regulations is reported, and standards regarding materials and furnishings are fully met. Annual monitoring of facilities.
Staff profile	Teachers: must have a degree in early childhood education and 3 to 5 years of experience.
	Teaching assistants: 5 O-levels (British educational model), including English and mathematics, or general academics. Early childhood education certificate, including internship. 3 years of experience.
	Aides: 3 O-levels, including English, or general academics. 1 year of training or early childhood education certificate.
Child-to-caregiver ratios (number of children per adult)	7.7 for ages 3 to 4
Monthly compensation	US$1,415.8 for teachers US$786.6 for teaching assistants US$550.6 for aides

Source and preparation: the authors.

age range. The centers provide lunch, although no minimum percentage of daily caloric requirements has been defined. The centers do not monitor the children's growth nor do they provide nutritional supplements. Table 95 also shows that centers maintain contact with parents through a communication log, and they hold quarterly meetings to discuss learning methods, health and nutrition.

Table 96 contains information about the regulations and standards at ECCE centers, while showing some basic data about staff. The centers mainly operate out of dedicated facilities, but they also function in community centers and alongside schools and churches (there are many cases like this since these centers were originally created with a strong connection to churches). ECCE reports that compliance with space requirements is about 30%, while compliance in regard to staffing, health and safety is between 90% and 100%. Monitoring visits are conducted annually for safety issues and quarterly for health issues.

Centers employ three types of staff: teachers (degree in early childhood development, three to five years of experience), teacher assistants (five ordinary levels,[20] child development certificate, internship and three years of experience), and aides (three ordinary levels, child development certificate and one year of training). These profile requirements are strictly adhered to, which ensures good quality staff at the centers. The wages for these three positions are US$1,416, US$787 and US$550 per month, respectively. The centers average a child-to-caregiver ratio of 7.7 children per adult (for ages 3 to 4).

4.19. Uruguay

The early childhood services in Uruguay included in the study are three programs that provide child care services, two of which are municipal programs in Montevideo and one national program. Table 97 offers an overview of the three programs' main features.

Table 97. Overview of major public child development programs visited in Uruguay.

Institution	Uruguayan Institute for Children and Adolescents	Government of the City of Montevideo	Uruguayan Institute for Children and Adolescents
Program	**CAIF Plan**	**Programa Nuestros Niños (PNN)**	**Programa de Primera Infancia (formerly Centros Diurnos)**
Children served (2011)	44,282	1,426	500
Age group served	0 to 60 months	7 to 60 months	0 to 48 months
Centers in operation (2011)	332	31	9
Staff (2011)	4,300	185	143
Operating schedule	11 months per year 5 days per week 4 to 8 hours per day, depending on the needs of the community. Rural CAIF centers usually provide 4 hours of care per day.	11 months per year 5 days per week 4 to 8 hours per day, depending on the needs of the families	12 months per year 5 days per week 2 sessions per day, lasting between 3 and 4 hours.
Geographic coverage	118 of the country's 547 localities	Attention only in Montevideo	Attention only in Montevideo
Target population	Vulnerable children	Underprivileged children whose development is at risk.	Low-income families
Targeting method	Information collected by specialists and an additional instrument used by the program	Targeting by location and a psychosocial worksheet that includes an income assessment.	Enrollment form.

Source and preparation: the authors.

[20] These correspond to high school exams of the education system in the English-speaking Caribbean.

The CAIF Plan (*Centros de Atención Integral a la Infancia y la Familia*) of the Uruguayan Institute for Children and Adolescents (INAU) came about in 1987 as a partnership between the national government and various civil society organizations to protect and promote the rights of children. It serves 44,282 children at 332 centers, distributed among 118 locations around the country. The centers operate 11 months per year, for four, six or eight hours per day, depending on the needs of the community (rural centers are usually open for four hours). The target population is vulnerable families, who are identified through a program instrument and through information collected by specialists in the areas where the program operates. *Programa Nuestros Niños* (PNN) of the city government of Montevideo was formed in 1990. It serves 1,426 children aged 7 months to 5 years, at 31 centers that operate much like CAIF Plan centers. The target population is children from low-income families, and targeting is accomplished through the location of the centers and a psychosocial worksheet.

INAU's *Programa de Primera Infancia* (formerly *Centros Diurnos*) is a child care service that works with children 4 and under. Created in 1980, it has not experienced significant increases in coverage since the program's emphasis has shifted toward expanding services through the CAIF Plan. It currently serves 500 children at nine centers in Montevideo. The centers offer two three- to four-hour sessions per day, 12 months per year. It targets low-income families through a registration form.

Although no financial data is available for the CAIF Plan, Table 98 shows valuable information about INAU's PNN and *Programa de Primera Infancia.* PNN has an annual budget of US$2.5 million, most of which is spent on salaries (81%), food (8.6%), and infrastructure (8%). The annual cost per child is US$1,941. INAU's *Programa de Primera Infancia* operates with a budget of US$1.5 million, which is mainly spent on salaries (70%), food (14%) and services (5%). Only families receiving services from *Programa Nuestros Niños* must make a payment, which averages US$12.8 per month.

Table 99 shows that care, food and nutrition monitoring components differ substantially among the three programs. The CAIF Plan offers different types of care depending on the length of the day (four, six or eight hours per day), which varies according to the needs of the community. The food provided differs by age group. All children receive lunch and,

Table 98. Income and expenditures of major public child development programs visited in Uruguay.

Institution	Uruguayan Institute for Children and Adolescents	Government of the City of Montevideo	Uruguayan Institute for Children and Adolescents
Program	**CAIF Plan**	**Programa Nuestros Niños (PNN)**	**Programa de Primera Infancia (formerly Centros Diurnos)**
Total expenditures (2010)	N/A	US$2,475,843.6	US$1,455,194.8
Infrastructure/ Maintenance		8.1%	4.7%
Wages		80.7%	70.4%
Training		2.6%	0.0%
Food		8.6%	14.1%
Administrative expenses		0.0%	1.8%
Services		0.0%	5.3%
Materials		0.0%	3.6%
Total income (2010)		US$2,768,306.5	US$1,455,194.8
Annual cost per child (2010)		US$1,941.3	US$2,910.4
Fees paid by families	No payment required	Between US$0.0 and US$17.9/month US$12.8/month, average	No payment required

The exchange rate used was the average from December 2010: 19.9 Uruguayan pesos per US dollar.
Source and preparation: the authors.

depending on the center's schedule, up to two additional snacks. When operating on an eight-hour schedule, centers try to provide 75% of the children's daily caloric. PNN operates four or eight hours per day, and the program provides lunch and an afternoon snack, with the goal to provide 70% of minimum calorie requirements. *Programa de Primera Infancia* offers two four-hour sessions, and the children at each session receive lunch and a snack. The program has no minimum caloric requirement.

The CAIF Plan takes anthropometric measurements on a bimonthly basis, the information is recorded, and a report is generated if problems are found. At PNN, the children are referred to a pediatrician at a health center who measures their growth every four months. Later, this information is used in the preparation of menus. *Programa de Primera Infancia* records measurements twice a month from the child's health record. The information collected is used to make adjustments to the food served.

All three programs work with parents in a similar manner. The CAIF Plan holds monthly sessions and workshops to address issues of nutrition, development and teaching methods, and it offers other sessions for expectant mothers. PNN offers workshops on similar topics but with varying frequency. *Programa de Primera Infancia* conducts bimonthly workshops on issues of development, child rearing, nutrition, health, the parental figure and children's rights.

Table 99. Components of major public child development programs visited in Uruguay.

Institution	Uruguayan Institute for Children and Adolescents	Government of the City of Montevideo	Uruguayan Institute for Children and Adolescents
Program	**CAIF Plan**	**Programa Nuestros Niños (PNN)**	**Programa de Primera Infancia (formerly Centros Diurnos)**
Components			
Child care services	Center-based care with children separated into age groups. Care for 4, 6 or 8 hours, depending on community needs.	Center-based care with children separated into age groups. Care for 4 to 8 hours, depending on the needs of the families.	Center-based care with children separated into age groups. Care with two sessions, one morning and one evening. Children are separated by age.
Food services	Food service depends on the number of hours the children are present. All children receive lunch and, according to the schedule, they may be given additional snacks. The goal is to provide 75% of daily caloric needs at centers open for 8 hours.	Lunch and afternoon snack are provided. They provide 70% of daily caloric needs.	Two sessions. Both receive a snack and lunch.
Nutritional monitoring	Bimonthly height and weight checks according to national guidelines. The information is recorded at the center, and the child is referred if problems are detected. A nutritional status report is generated.	A pediatrician at a health center weighs and measures the children every 4 months. Results are considered when planning the children's food.	Measurements are recorded twice a month from the child's health record. The information collected is used to make adjustments to the food served.
Parental support	Monthly sessions and workshops discussing nutrition, development, and teaching methods and work with pregnant mothers.	Nutrition issues are discussed at sessions and workshops held at varying intervals.	Bimonthly workshops on issues of development, childrearing, nutrition, health, the parental figure and children's rights.

Source and preparation: the authors..

The CAIF Plan operates out of different types of facilities: its own centers, facilities attached to schools or churches, and community centers. Although the program reports that standards are met at almost all centers, it also acknowledges that some do not meet minimum space requirements. PNN only operates out of its own centers, and the program reports that 70% meet minimum standards. It also reports that health and safety regulations are met at all sites. *Programa de Primera Infancia* functions solely at its own centers, and the program reports that these centers fully comply with standards and regulations.

Both INAU programs employ staff with similar profiles. Both hire teachers (with specialization in early childhood education, no experience necessary) and educators (with high school diploma and 500 hours of basic training in early childhood). *Programa de Primera Infancia* also hires social educators (with a degree in this field). At *Programa de Primera Infancia*, the salaries for these three types of staff are US$844, US$738.6 and US$867.7, respectively. For its part, PNN hires three types of staff, which include teachers (graduates of the *Instituto Magisterial Superior*, with some experience with children), educators

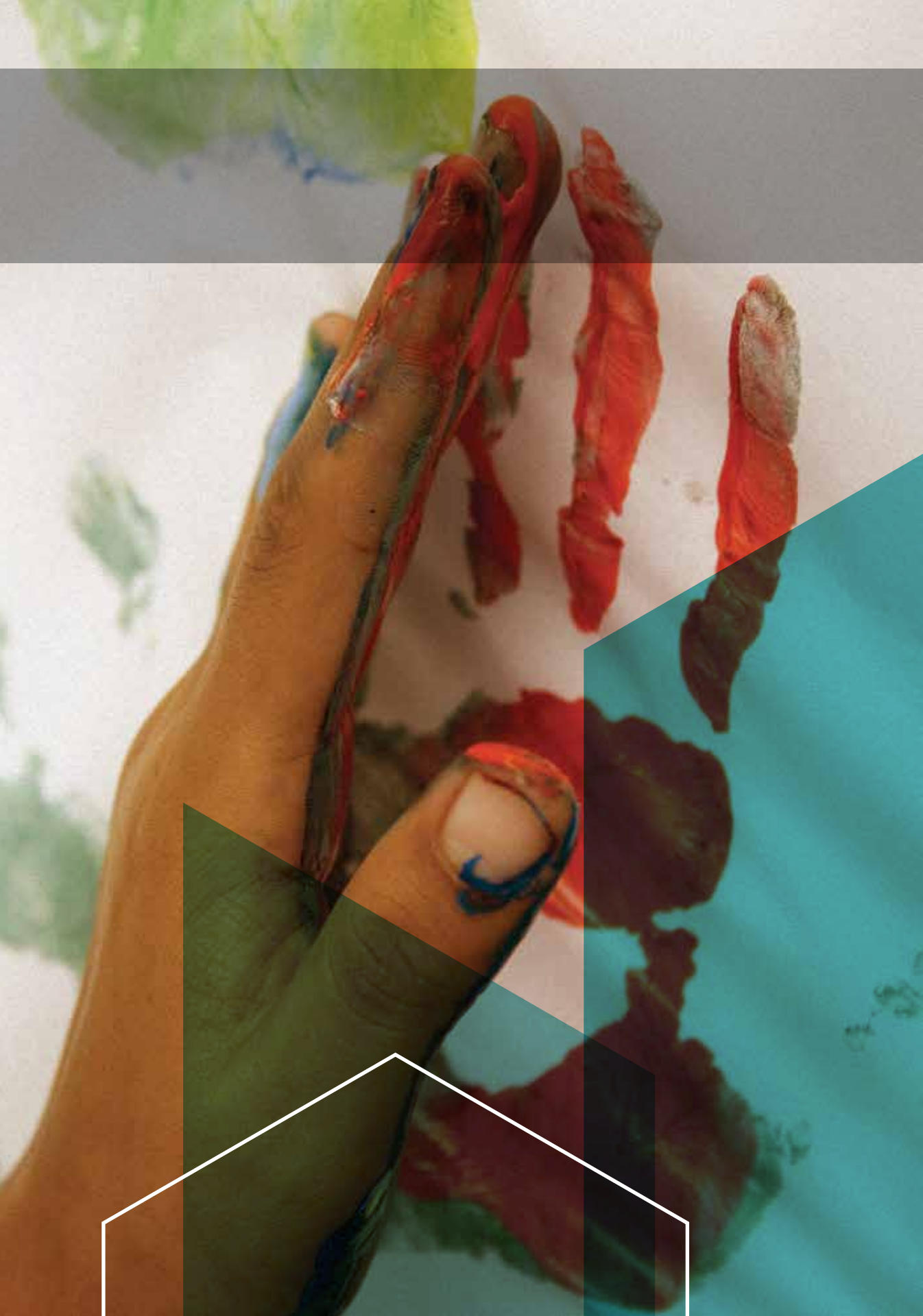
Table 100. Infrastructure and human capital of major public child development programs visited in Uruguay.

Institution	Uruguayan Institute for Children and Adolescents	Government of the City of Montevideo	Uruguayan Institute for Children and Adolescents
Program	**CAIF Plan**	**Programa Nuestro Niños (PNN)**	**Programa de Primera Infancia (formerly Centros Diurnos)**
Quality			
Site where program operates	- Mainly at program centers - Facilities attached to a church or school - Community centers	- Only at centers exclusive to the program	- Only at centers exclusive to the program
Standards	Criteria and quality standards set by the program are met in full, except for a few centers with inadequate space.	Criteria and standards in regard to staffing at the centers have 70% compliance. Health and safety regulations are met without a problem.	All facilities comply with established regulations and quality standards. This is related to the low number of centers in the program.
Staff profile	Teachers: must possess specialization in early childhood education. In other words, a high school diploma plus college degree related to early childhood. No work experience required.	Teachers: they must be graduates of the Instituto Magisterial Superior, preferably in early childhood education. 0 to 3 years of experience working with children are required.	Teachers: a teacher specialized in early childhood education is required. This profile is not fully met.
	Educators: must have high school diploma plus 500 hours of basic training in early childhood.	Educators: high school diploma required, with consideration during the selection process given to additional courses and training.	Social educators: degree in social education. No experience necessary.
		Food educators: same requirements as educators, but they work with families on nutrition issues.	Educators: must have high school diploma. The minimum requirement is not completely satisfied.
Child-to-caregiver ratios (number of children per adult)	10.1 for ages 0 to 2 12.2 for ages 2 to 6	4.3 for ages 0 to 1 5.2 for ages 1 to 2 6.8 for ages 2 to 4	2.8 for ages 0 to 1 5.4 for ages 1 to 2 10.8 for ages 2 to 4
Monthly compensation	US$832.0 for teachers US$702.0 for educators	US$1,301.6 for teachers US$860.2 for educators US$988.5 for food educators	US$844.0 for teachers US$867.7 for social educators US$738.6 for educators

Source and preparation: the authors.

(high school diploma, with post-secondary training preferred) and food educators (high school diploma), who work with families on nutrition issues. The salaries they receive are US$1,301, US$860 and US$989 per month, respectively.

Lastly, Table 100 shows that child-to-caregiver ratios vary greatly between programs. The CAIF Plan maintains a ratio of 10.1 children per adult for ages 0 to 2 and 12.2 for ages 2 to 6. PNN reports 4.3 children per adult for ages 0 to 1, 5.2 for ages 1 to 2, and 6.8 for ages 2 to 4. *Programa de Primera Infancia* operates with a lower ratio than the CAIF Plan: 2.8 children per adult for ages 0 to 1, 5.4 for ages 1 to 2, and 10.8 for ages 2 to 4.



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