PRIMEIRA INFÂNCIA MELHOR

TRANSFORMING ATTENTION TOWARDS THE FIRST YEARS OF LIFE IN LATIN AMERICA: CHALLENGES AND ACHIEVEMENTS OF A PUBLIC POLICY IN SOUTHERN BRAZIL

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GOVERNO DO ESTADO RIO GRANDE DO SUL SECRETARIA DA SAÚDE

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Preface

The findings of science, in relation to the development of human skills and abilities, point to a crucial interaction between genes and the environment. Natural selection has been perfecting this process to ensure a survival of each individual under increasingly better conditions.

In the early stages of evolution, genetic programming, enhanced by the ability to survive and to reproduce, prevailed. This capacity has expanded over time. That was when genes created an organism's ability to go beyond previous programming, and to develop new mechanisms of adaptation to the environment, orchestrated by brain function.

Human being is the most recent and sophisticated fruit of this process and have the most complex brains. They are born with physical and mental development in their initial phases and with skills that are minimally outlined. For them to become more elaborate, they will require more maturing. Thus, we are very fragile and dependent upon birth, and we will go through a long childhood, because our powerful brain needs much more time to develop. Our competencies will be organized in stages and will be very dependent on the adaptation to the most varied environments. From the sensory perception of the surrounding world, from the formation of memories about all important information, until cognitive explosion, several years will go by which characterizes what we call early childhood. The plasticity of the brain will be extraordinary in these first years of life, and it will be decisive for the unique human cerebral architecture. In no other period of life there is such an intense and fast period of learning.

Since the human brain is born to learn from the particular world in which it will live, the intermediation process provided by caregivers is decisive for its organization. At every stage of their development, the fetus, the baby, and the small child need so much adults that are understanding and affectionate caregivers, the ones who understand the importance of each stimulus at each moment.

In this way, caregivers, whether parents, relatives, or even unrelated practitioners, will have a decisive and transformative influence; thus helping to shape the mind and the brain of the children, which will have repercussions throughout their life.

With this in mind, public policies were developed in the world and in Brazil; revolutionary policies aimed at providing child development in the best possible way to all families. In our country, the pioneering Public Program was *Primeira Infância Melhor* (Better Early Childhood) - PIM, which started in 2003 in Rio Grande do Sul, and has accompanied hundreds of thousands of children during their first years of life. After it, other programs in other states appeared, such as the Legal Framework for Early Childhood (Marco Legal da Primeira Infância), and now there is a major National Program for 4 million young children called *Criança Feliz* (Happy Child). Somehow, all were inspired by PIM, which celebrates 14 years of existence and has been transforming the life of the local children and their families for the better. Congratulations to all who took part in this wonderful and transformative process.

Osmar Gasparini Terra
Minister of Social and Agrarian Development
and founder of *Primeira Infância Melhor.*

Gaps in the development of children become evident from the earliest years. That is why early childhood was recently highlighted on the agenda of most Latin American and Caribbean countries. Governments are focusing their efforts mainly on expanding the coverage of child care services. However, there are other modalities for early childhood care, which definitely makes the state of Rio Grande do Sul a pioneer.

One of the main questions that public policy managers focused on early childhood faces today is: what is the best intervention to serve this population? Providing answers to this question is not an easy task, because, on the way, one must answer several other questions that brings about the understanding of the reality of each country, culture, or specific population; among them: specifically, what do we want to change in the behavior of families, mothers and/or caregivers? What human and financial resources do you count on to carry out this intervention? What is the institutional capability? Of course, there is no single recipe for promoting child development.

The State of Rio Grande do Sul, Brazil, as well as other countries in Latin America, recognized the importance of investing in early childhood, and that is why they started a comprehensive policy fourteen years ago, the Primeira Infância Melhor Program (PIM). This publication goes beyond a description of the PIM. From a critical and objective point of view, it allows a deep understanding of the design and implantation, as well as the challenges and achievements of a program that has been able to last over time and which has inspired other municipalities, states, and even other countries in the region. This document could not be more timely and relevant, since the current expansion of the Criança Feliz national program uses PIM as its primary benchmark.

This publication addresses relevant issues from a PIM perspective to the debate on how best to care for children under the age of six, such as quality assessment, the role of intersectorality, the presentation of an information system, and the importance of rigorously assessing program impacts. The latter is addressed in detail, since it is the main challenge facing the PIM. The results of the first efforts are presented for evaluation, and a cost-benefit analysis is developed, it is developed as an illustration, using a more rigorous assessment of its impact so far as a starting point.

The language and structure used in this document allow it to be interpreted as a toolkit for policymakers, in which - rather than dictate parameters or determine what is and is not correct - the path taken to ensure that children achieve excellent development is traced. I believe this work offers several original contributions. First, it synthesizes the trajectory of one of the most important regional home visits programs in a single publication. Secondly, it discusses in detail the important aspects to be considered during the implementation and adaptation of a program of home visits. Thirdly, it openly discusses the challenges and achievements of the program so that the reader can consider all the necessary variables for decision making. Finally, it is presented in Spanish, English, and Portuguese, in order to facilitate the access of readers from all over Latin America.

This publication will serve as a guide for policy makers in Brazil and in other countries, as well as for researchers and practitioners interested in translating the debate about improving child development indicators into action and concrete results. I'm sure they will enjoy reading it and it will be very useful.

Florencia Lopez Boo
Senior Economist, Social Protection and Health Division, IDB.

A Child. We must call it by name because it is its identity, its life project. The name expresses the strength that comes from within to take place in history.

Better Early Childhood (Primeira Infância Melhor) is its baptism name. Beautiful, it says so much about this "person" that it almost describes it to those who do not know it. There, like the genetic load, is the essence of what is and what it means, the purpose it came for, the reality that is prepared to build, and the life it is to live. Although the three words form a unique sense, each has its own content. To explore their meanings is to take away the veil that covers a face and to see it better. Routine in the use of words weakens our encounter with the depth they hold.

Childhood, beginning of life, the first cycle of human existence. That is not where everything begins, because it is preceded by energy that is intrinsic to life and tends to perpetuate itself in the succession of people and generations. And at birth, the encounter with light occurs. The time when children begin to see the world, to discover where they are, who they are with, and feel welcomed, cared for, protected, and loved. It is a time of bonding, which provides emotional security, forms secure references in a multitude of things and people, loves and deceptions, achievements and frustrations.

The Program's name adds an adjective to childhood. *Early*. More than positioning childhood in time, it qualifies it. It is the inaugural period, which places the baby in the network of intersubjective relations and begins to make it a subject. It is early because it implants the foundations of personality: the foundations of emotional life and socialization, and the structure of intelligence, communication, and language. In these early years the child seizes, creates, and uses multiple ways of communicating and affirming itself to others.

There is another adjective in the Program's name: *Better*. Not every childhood is good. There are children excluded from everything, even affection. There are unknown, isolated childhoods pushed into the shadow of public policy. For these, it is necessary to provide a childhood, ensuring the right to be a child and live as a child. And there are well cared for, protected childhoods, surrounded by means that are favorable for their full development. This isn't a privilege, but a right. Therefore it is everyone's right. This childhood with full rights and living is an inspiration, if not an order, so that all children of all childhoods are welcomed, protected, loved, and have their needs met. Therefore, the motto "Not One Less" can be applied to the Program's scope 1. A policy for Early Childhood is guided by justice, equity, and equal opportunities.

Primeira Infância Melhor... this is the name, this is the Program, vision, and mission of a public policy geared towards the first six years of life. The focus is the child in the family, but open to public institutions in the territory that complement family action - health center, day care, preschool, social care centers, law and tutelary boards, in short, the agencies of the system to ensure citizen rights.

A Child. We must call it by name. But in this case, it is worth having a second name, abbreviated and almost childlike, in their style: PIM. And PIM traveled to other states and became known, inspiring home visit programs that were created with adaptations to the geographical and cultural features of the respective region and designed by the creativity of the public managers and the professionals who engaged in it.

Vital Didonet
Consultant for legislative affairs of the
Early Childhood National Network.

1 Not One Less - English title of the 1999 Chinese film directed by Zhang Yimou.

Acknowledgments

"Every acknowledgement is a memory of the heart" (Lao Tsé)

In addition to the recognition of the importance of early childhood by society, it is important to remember that investments in causes of such greatness have only resulted from the initiative of people who believe and bet on ideals. In this sense, it is appropriate to mention, affectionately and respectfully, some specific people directly responsible for the success and growth of *Primeira Infância Melhor* - PIM. These people represent all those involved, who believe in and fight for early childhood:

Osmar Gasparini Terra, creator of the proposal for intervention in early childhood, manager when *Primeira Infância Melhor* was founded, who directed the cause as an institutional priority in his management;

Arita Bergmann, whose management of PIM made possible its implementation with the State Department of Health;

Leila Almeida, PIM State Coordinator for a long period, who conducted the management actions with special affection and technical quality, supporting the work of a competent team of professionals;

Liése Gomes Serpa, for her Coordination of the Program in a period of intense interaction with health policies and important advances for the maturation of PIM;

Gisele M. da Silva, current PIM Adjunct Coordinator, for her competence and dedication to PIM since its inception, and for being a promoter of the actions that increase the quality of the Program, guaranteeing its sustainability and visibility;

Francisco Paz, current PIM Coordinator, for his constant support in the execution of the Program and for trusting the professionals that are responsible for its technical management.

The *Educa a Tu Hijo*/Celep program, a carefully chosen institution to support the PIM principles, whose professionals supported the implantation and implementation phase of the program;

National Early Childhood Network, which, par excellence, works in partnership supporting and fostering actions in favor of attention toward the first years of life and inspires us in the struggle for a better childhood throughout Brazil;

The IDB team, particularly Florencia López Boo, for trusting PIM and fully funding this book, and for contributing to the analysis and all its revisions with the support of Mayaris Cubides;

The Maria Cecilia Souto Vidigal Foundation, for its partnership with this and other initiatives, and for fostering a culture of care with the first years of life in Brazil;

Victor Guerra, for improving our view on the importance of rhythm and affectivity as organizing principles of the affectional bond, strengthening our enthusiasm to bet on the ability of families to establish sensitive and loving relationships with their children;

Vital Didonet, for inspiring us with his affection, wisdom, and ability to aggregate in order to build a better country for our children. His support and example are fundamental for our trajectory;

Karine Isis Bernardes Verch, for the dedication and competence with which she translated our journey in this book - which is also hers;

Giuliana Chiappin, for accompanying the production of this book with her attentive and careful oversight;

Professionals of the PIM State Technical Team at the central level and Regional Coordinators, who invest their knowledge and love in everything they do, day after day, always thinking about the best for families, pregnant women, and children;

State managers from Rio Grande do Sul, from different administrations that, independently of political-partisan issues, offered conditions for the continuity and strengthening of the PIM's actions;

State Departments that partnered with the Program, for their constant support in early childhood care actions;

Municipal managers, who adhered to the proposal, providing working conditions for PIM efforts, along with the care network and families.

Service network professionals, by partnering to promote integrated care in early childhood development;

Municipal Technical Groups (GTM) and PIM Monitors, for their permanent effort to ensure quality care for families and to promote early childhood as a priority in municipal administrations;

PIM visitors, professionals directly linked to communities, responsible for guiding families to strengthen their skills for the care, education, and protection of their children, thank you for making this possible;

To families, pregnant women, and children who entrust their experiences to PIM, providing the co-construction of this public policy into a mutual, transforming, powerful, and passionate learning experience.

State Team for
Primeira Infância Melhor

Presentation

This book tries to dive into the unique and innovative journey of a Program that brought light to the way we understand childhood in our times. Its production was supported by the Inter-American Development Bank and the Maria Cecilia Souto Vidigal Foundation and, at all stages, received close attention from the PIM State Team.

Our history began during the early days of March 2003, when Rio Grande do Sul embraced the challenge of implementing a strategy that considered human development from a holistic approach. The *Primeira Infância Melhor* (PIM) program was born, an unprecedented initiative in Brazilian history.

Over these 14 years, PIM has provided us with experiences that transform our way of looking at and believing in the life and potential of each subject to build their own path. These changes were closely related to our personal values, but especially our responsibility as professionals to construct public policy centered on respect for singularities, defense of rights, unity of efforts, struggle for social inclusion, and fidelity to our main desire: to contribute to ensuring that all children have the opportunity to grow and develop in a healthy and welcoming environment. The path, even if sinuous and full of challenges, continues to reap success. We learn and we continue to learn from the families, the daily life of the communities, and the efforts of the workers in the territories. In a special way, we learn from the power of affection and from the play of the children among their discoveries about the world.

We share the certainty that being part of the *Primeira Infância Melhor* team expands our duty to share this learning, being example and inspiration for other initiatives. Therefore, this publication integrates our efforts to contribute and encourage those who wish to follow similar trajectories.

The PIM technical team is proud of every step of the story here. This is the fruit of our daily struggle to overcome the challenges and to achieve our desire to indelibly mark the memory and heart of all who, for any reasons, walk or walked in our paths and let themselves be taken by a greater love: early childhood - the beginning of life - the beginning of all.

Gisele Mariuse da Silva
Adjunct State Coordinator of
Primeira Infância Melhor

List of Abbreviations and Acronyms

ACS	Community Health Worker
AIS	Indigenous Health Agent
AISAN	Indigenous Sanitation Agent
BPC	Continually Rendered Benefit
CELEP	Latin American Reference Center for Preschool Education
CNS	National Health Card
CONANDA	National Board for the Rights of Children and Adolescents
CRAS	Social Assistance Reference Center
CRE	Regional Education Office
CRS	Regional Health Office
ECA	Child and Adolescent Statute
ESF	Family Health Strategy
FIOCRUZ	Oswaldo Cruz Foundation
FNDE	National Education Development Fund
GTE	State Technical Group
GTM	Municipal Technical Group
HDI	Human Development Index
IBGE	Brazilian Institute of Geography and Statistics
INEP	Anísio Teixeira National Institute for Educational Research and Studies
LDB	Law of Guidelines and Fundamentals
LOAS	Organic Social Assistance Law
NIS	Social Identification Number
PACS	Community Health Worker Program
PBF	Programa Bolsa Família (Family Stipend Program)
PIM	Primeira Infância Melhor (*Better Early Childhood*)
PNAD	National Survey by Domicile Sample
PNAISC	National Policy for Integral Child Healthcare
PNE	National Education Plan
PNPI	National Plan for Early Childhood
RNPI	National Early Childhood Network
RS	Rio Grande do Sul
SES	State Department of Health
SESAI	Special Indigenous Health Department
SIAB	Basic Care Information System
SisPIM	PIM Information System
SUS	Unified Healthcare System
UBS	Basic Healthcare Unit
UMI	Maternal-Child Unit
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

List of Documents

1. Quarterly Descriptive Monitoring
2. Monitoring of PIM Participants
3. Expansion of Number of Visitors
4. Evaluation of Child Development
5. Characterization and Diagnosis
6. Census/Mapping
7. Visitor Deactivation
8. Program Deactivation
9. Initial Diagnosis of Child Development (Baseline)
10. Orientation Guide for Visitor Initial Training
11. Monthly Memo
12. Quarterly Memo
13. Monitoring of Integral Child Development
14. Quarterly Descriptive Opinion of the Pregnant Woman
15. Action Plan
16. Visitor Initial Training Plan
17. Care Modality Plan
18. GTM and Monitor Initial Training Program
19. Visit Record
20. Monthly List of Pregnant Women and Children Cared For
21. Assistance Script
22. Monitoring Script of PIM Action in the Municipality
23. Home Visit Observation Script
24. Early Childhood Situation in the Municipality
25. Temporary Suspension of the Program
26. Participation Agreement

Contents

Introduction

The *Primeira Infância Melhor* Program – PIM an intervention to strengthen families in their skills and to promote the development of early childhood, in articulation with healthcare, social assistance, and education as a priority.

This publication aims to present the trajectory covered by PIM, depicting its structure, operation, and peculiar methodology, as well as the advances and challenges faced by this public policy. In addition, it intends to provide information for initiatives that seek to implement early childhood care services.

Chapter 1 - The *Primeira Infância Melhor* Program - PIM - brings a historical retrospective of the legal and theoretical context for early childhood care at the national and global levels, and how this context motivated and influenced the creation and improvement of PIM, and how the Program has also influenced this context. The PIM axes are presented, as well as the importance of a public policy focused on integral care and how this policy is implemented in practice. We also describe the process of home visitation and playfulness, validated as PIM intervention technologies within the families.

Chapter 2 - Structure and operations - presents the structure and operations of *Primeira Infância Melhor* regarding its technical guidelines, human resources, team formation, and stages that make up the participation, implantation, and implementation of this public policy. It also presents the criteria for selection and profile of the beneficiaries, as well as explaining budget and financial resources for the Program's sustainability.

In chapter 3 - Monitoring to ensure PIM quality -, the process of monitoring *Primeira Infância Melhor* is discussed. As one of the aspects of ensuring the success of the Program, the levels of monitoring action in practice are presented in detail: for the pregnant woman and the child; the activity of the Visitor, and the municipal teams. Finally, from a critical point of view, it presents the studies that have been carried out to assess the Program.

Chapter 4 - Innovating early childhood care - demonstrates its impact on strengthening a culture of investments in early childhood. In addition, there is a reflection on the difficulties in executing *Primeira Infância Melhor*, allied to the lessons learned in the daily practice of this public policy.

This publication seeks to translate the trajectory of fourteen years of an innovative public policy, created in a scenario in which actions in favor of early childhood care were rare or incipient. Among the PIM achievements are its recognition as a priority project in the different state administrations, which, regardless of partisan situations, were unanimous in relation to the relevance of the continuity of the Program. In addition, PIM supports the implantation of similar initiatives in other regions of Brazil, and it contributes to the elaboration of documents and legislation related to the subject.

We hope this publication may be usefull as reference for those who seek to invest in actions that improve early childhood care, becoming the foundation of a more just and egalitarian society.

CHAPTER 1

PRIMEIRA INFÂNCIA MELHOR PROGRAM - PIM

Primeira Infância Melhor is a transversal public policy of socio-educational action to promote integral development during early childhood. Its main objective is to guide families based on their own culture and experiences in order to promote the integral development of their children, from pregnancy time until the year of six. Through home visits, PIM promotes child development, the strengthening of family bonds and the identification of the specific needs of each beneficiary, connecting the service network according to the demands that arise in the day-to-day family activities.

The PIM trajectory: historical and legal context

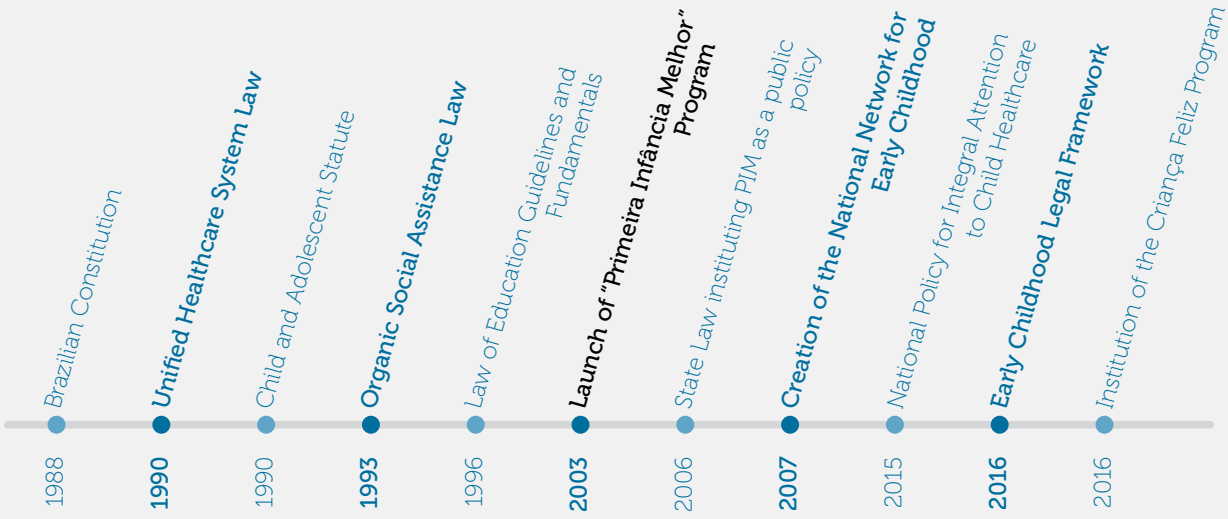
Over the last decades, different treaties and legislation have addressed issues related to early childhood. The Brazilian Constitution (1988), the Convention on the Rights of the Child (UNICEF, 1989), the Jomtien Declaration and the Dakar Declaration (UNESCO, 2001a) are significant examples that recognize the child as an individual with rights and within a peculiar development condition. These documents compromise governments and society to the promotion of actions aimed at guaranteeing, beyond survival, full development and protection against all forms of discrimination, exploitation, and abuse, with a priority focus on those children who are in a situation of biopsychosocial vulnerability.

Brazilian legislation followed the process of early childhood care in different sectors of government, such as the implantation of the Unified Healthcare System - SUS (Federal Law no. 8,069, 1990), which advocates maternal and child care; the Child and Adolescent Statute - ECA (Federal Law No. 8.069, 1990), which guarantees the rights of the integral development of the child, complementing the action of the family and the community; the Organic Social Assistance Law - LOAS (Federal Law No. 8,742, 1993), which has among its purposes the protection of the family, maternity and childhood; and the Law of Education Guidelines and Fundamentals - LDB (Federal Law no. 9,394, 1996), which integrated early childhood education into the educational system. In 2001, the National Education Plan (PNE) presented specific guidelines and objectives for the age group from zero to six for the first time (UNESCO, 2001b).

Driven by these laws, in 2003 the *Primeira Infância Melhor* Program was implemented in the state of Rio Grande do Sul - RS[2], in response to latent demands for early childhood care.

Different global initiatives were analyzed to provide a basis for the PIM implantation project. The methodology of the Cuban program *Educa a tu Hijo*[3] was chosen to be

Figure 1 - Timeline



2 Brazil is a federative republic formed by the union of 26 federal states and the Federal District. Brazil is organized in three interdependent spheres: federal (corresponding to the entire country), state (the 27 states that make up the country) and municipal (division of municipalities within each state). Each of these spheres has its own structure and management. Rio Grande do Sul is the state located in the extreme south of the country corresponding to approximately 3% of the national territory. The State has an extensive area of 268,000 km², where 497 municipalities are populated by approximately 10 million inhabitants (6% of the Brazilian population).

the inspirational model for the Program's basic guidelines. With this, a three-year technical cooperation agreement was established, funded by the State Health Department (SES), which enabled the exchange of experiences and fundamental knowledge to overcome the challenges inherent in the implementation of an unprecedented public policy in Brazil. The Program also established technical cooperation with the United Nations Educational, Scientific and Cultural Organization (Unesco) in order to facilitate their State management activities.

In 2003, the scenario in Brazil was only 21.8% of the population from zero to six years old with care in the infant education system. In Rio Grande do Sul, the percentage was even lower, 17.9%, representing 218,976 of a population of 1,220,351 children (IBGE, 2005). The percentage of underweight children in the areas covered by the Family Health Strategy (ESF) in Brazil was 4.8% up to the first year and reached 10.1% at two years of age (UNICEF, 2006) 4. The percentage of poor children, with family per capita income of up to ½ a minimum wage, was 45% in Brazil and 28.8% in RS (IBGE, 2004). The infant mortality rate in 2003 was 24.6 deaths per thousand live births in Brazil and 15.9 deaths per thousand live births in RS. The Human Development Index - HDI of Brazil was 0.79, i.e., the country ranked 63rd in the global ranking among 177 countries (UN, 2004, IBGE, 2005).

By December 2006, PIM was implemented in 45.5% of the municipalities of Rio Grande do Sul, assiting 40,125 families and benefiting 4,815 pregnant women and 44,138 children, equivalent to 6% of the children not enrolled in the formal education system for children (Schneider & Ramires, 2007). The visible results of this public policy strengthened the appreciation of early childhood among managers of the State Health Department and the other departments involved. At the same time, there was a recognition by the state government, which in 2006 established the Program as an integral part of the State Policy for the Promotion and Development of Early Childhood through State Law no. 12,544. The institution of this law ratified the pioneering investment in families with young children in the south of Brazil.

In 2007, when technical cooperation with the Latin American Reference Center for Preschool Education - Celep/Cuba ended, together with the technical strengthening and legitimization of the Program, there was a need to improve its methodology, adapting it to the needs and peculiarities of Brazilian culture. Since then, the process of monitoring child development has been implemented, not recommended in the model adapted from the *Educa a tu Hijo* program.

In that same year, an important advance in the first years of life in the country was the creation of the National Early Childhood Network - RNPI, a national articulation that brings together organizations from civil society, government, the private sector, and other networks, and has important power of technical and political incidence in Brazil. *Primeira Infância Melhor* has been representative since its inception, having formed a management group for two terms. In 2010, RNPI was granted approval from the National Board for the Rights of Children and Adolescents National Council for the Rights of the Child and Adolescent (Conanda) for the National Plan for Early Childhood (PNPI), which which has been penned by PIM, among other institutions.

In this trajectory, two Federal initiatives were developed: Estratégia Rede Cegonha (Stork Network Strategy - Federal Directive No. 1459, 2011), which proposed a new model of care for childbirth and child health in the early years, and Programa Brasil Carinhoso (Affectionate Brazil Program), which considers PIM one of its pillars and seeks to contribute to integral care

3 *Educa a tu hijo*, coordinated by the Latin American Reference Center for Preschool Education - Celep is a Cuban social program that offers non-institutional educational attention to children from zero to six years old who do not attend educational institutions. It is community oriented and eminently intersectoral. It focuses on the family as agents to promote the integral development of their children, in order to prepare them for school.

4 At that time, there was no comprehensive specific picture of early childhood malnutrition in Brazil. The available data refer to the population assisted by the Community Health Worker Program (PACS) and the Family Health Strategy (ESF), based on data from the Basic Care Information System (SIAB) of the Ministry of Health.

actions during early childhood by acting in different aspects, such as food and nutritional safety, and guaranteeing children the right to access and to remain in early childhood education.

In 2012, the PIM methodology was altered with respect to the number of families assisted by the Visitor. In order to achieve a higher quality of care for the beneficiaries, with an increase in the estimated time for planning the visits and the permanent education of the Visitor, the maximum number of families attended by the Visitor was reduced from 25 to 20 families (State Directive no. 578, 2013).

The consolidation of the importance of early childhood was strengthened in various sectors. The National Education Plan - PNE (Federal Law no. 13.005, 2014) presented goals related to early childhood education, which provided for the care of 100% of the children of four and five years old in preschool until 2016, in compliance with Constitutional Amendment no. 59/09, as well as 50% of children up to three years of age in day-care centers by the end of PNE's effective decade, in 2024. To comply with this change *Primeira Infância Melhor* adjusted its form of care to families with children again, reorganizing its care system by age group.

Brazilian society had another achievement to celebrate in 2015, when National Directive no. 1130 was published, establishing a National Policy for Integral Child Healthcare - PNAISC. PNAISC. This Directive contains PIM contributions in its body text, and it recognizes the importance of the first years of age by foreknowing , in its third axis, the integral development of early childhood, whose actions meets with PIM its methodological reference.

In 2016, as a result of the technical support from the PIM state team and inspired by them, the state of Amazonas created its own law aimed at early childhood care. Only 2 of the 27 states in the national territory have their own laws. Besides that, the 10 year interval between each legislation reveals that the prioritization level for the first years of life is still a national challenge (State Law no. 4.312, 2016).

In that same year, a historic breakthrough was the approval of the Legal Framework for Early Childhood, Federal Law no. 13.257/16 which aims to ensure rights in several sectors aimed at promoting integral development, using PIM as a model benchmark for home visitation.

A resulting action of the Early Childhood Legal Framework was the creation of the *Criança Feliz* Program: a federal government program that aims to support families to promote child development. It's a large-scale action that prioritizes pregnant women and children of families who are members of the Bolsa Família[5] (PBF) program, families with children with disabilities receiving Continually Rendered Benefit (BPC), and also children deprived from family interaction (Federal Decree no. 8.869, 2016). Inspired by the methodology of *Primeira Infância Melhor* and other programs in other states, *Criança Feliz* will focus its attention primarily on the first thousand days of life, through home visitation.

The constant practice of supporting different initiatives for the first years of life confirms the importance of *Primeira Infância Melhor* on the national scene. Throughout its trajectory, it has served as a methodological benchmark and has supported different states and municipalities of Brazil. Some highlights include: *Atenção à Primeira Infância e à Maternidade* - Munhoz de Melo/ Paraná (2012), *Atenção Melhor à Infância* - Vila Velha/Espírito Santo (2012), *Programa Primeira Infância Ribeirinha* - Iraduba, Novo Airão and Manacapuru/Amazonas (2013), *Programa Cresça com Seu Filho* – Fortaleza/ Ceará (2014), *São Paulo Carinhosa* - São Paulo/ São Paulo (2014), *Projeto Atenção Nutricional e Estímulo ao Desenvolvimento da Primeira Infância* - 28 municipalities in Acre, Amazonas, Roraima, Rondônia, and São Paulo (2014), *Primeira Infância Acreana* – Acre (2015) and a program under construction in Alagoas (2016)[6].

When analyzing the current scenario regarding

5 Bolsa Família (Family Stipend) is a direct income transfer program for families living in poverty and extreme poverty throughout the country. The Continually Rendered Benefit is an individual benefit that guarantees the transfer of a minimum wage to the disabled person of any age who proves that they do not have the means to support themselves or to be supported by their family.

state and national data and indicators, there is an increase in the presence of children in the preschool education system. According to data from the School Census, Brazil currently has 29.6% of children from zero to three and 89.1% of children from four to five years old enrolled. In Rio Grande do Sul, this percentage is 32.8% of children from zero to three and 80.1% of children from four to five years old enrolled in the preschool education system (INEP, 2015). The increase in the number of openings available in the formal education system has consequently impacted the number of care instances for *Primeira Infância Melhor*, which had a significant drop in care for children as of four years of age. On the other hand, a positive aspect of this change was the possibility of placing greater emphasis on working with pregnant women and babies, a crucial period for interventions to promote integral development.

In recent years, Brazil has made progress in reducing child mortality, whose rate fell from 62 deaths per thousand live births in 1990 to 13.8 per thousand live births (Berlinski & Schady, 2015), representing a fall of more than 10 percentage points compared to 2003, the year PIM was implemented. In Rio Grande do Sul, the infant mortality rate was 10.1 deaths per thousand live births (Portal Saúde, 2016), showing a decrease of 5.8 percentage points in relation to 2003. According to the Food and Agriculture Organization of the United Nations (FAO) report (2014), Brazil has also succeeded in reducing social inequalities by halving the population suffering from hunger, and was omitted for the first time from the World Famine Map, with an important impact on the health of children and vulnerable populations. In relation to the Human Development Index (HDI), Brazil was ranked 63rd in 2003 but ranked 75th in 2015 (UNDP, 2016). Regarding specific data for Primeira Infância Melhor (SisPIM, 2016), at the end of 2016, the Program had been implemented in 242 municipalities, representing 49% of the state, assisting 51,700 families, and benefiting 7,755 pregnant women and 58,870 children.

Support Axes

The support axes of *Primeira Infância Melhor* are: family, community, and intersectoriality. These axes have been present since the conception of the Program and are one of the key to success since they represent three basic premises: the leading role of the family, community involvement, and the active participation of different management sectors.

In this context, family is understood as the place where bonds of affection and coexistence are established and sustained. It is where children, parents and/or caregivers, and relatives, regardless of biological ties, are concretely and symbolically mobilized. It is a space where the actions of the Program make sense as the primary place for socialization, learning, and the development of human capabilities (Almeida *et al.*, 2016).

PIM proposes to welcome and respect the singularities of each family, investing in the co-construction of a dialogical relationship based on ethical conduct, which includes differences and values the potential of each context. It is a permanent coproduction exercise of health and autonomy of the subjects, and therefore does not represent a work of family tutelage. PIM is a socio-educational action that motivates the reflective participation of families in the proposed activities and continuity of the care for their children (Drügg, 2011). This seems to be the way that makes it possible to work towards strengthen families, which begins by understanding each family's way of life, providing them with personalized assistance

6 The years cited represent the beginning of the partnership between the programs and PIM, and in some cases the technical support remains to this day.

that respects their cultures and experiences.

The communities are understood as the expansion family coexistence space. A space where the subject can exercise its singularity, and at the same time it is mixed with and undergoes influence from other knowledge, cultures, histories and experiences. Under this rationale, the community establishes itself as an exercise of the collective, in which the individuals change also transforms the context around them.

PIM's actions seek to strengthen communities. In addition to home visits and group activities, the Program regularly promotes community activities, with the participation of different segments of the community, aiming to socialize, strengthen local culture, while promoting rights and access to information, among others. In this scenario, PIM is now recognized as part of the community itself.

One aspect that emphasizes the value given to the community axis is the methodological adaptation that takes place in the work with the so-called "traditional communities": indigenous and *quilombolas*, as well as the specific ones: on the riverside, in the countryside, the forest, the waters, and incarcerated mothers. Appendix 1 briefly presents experiences and lessons learned from PIM adaptation projects in *quilombola* and indigenous communities and with incarcerated women.

The intersectoriality is understood as an articulated set of actions, of different areas and actors, seeking the integral care of pregnant women, children, and families. This is presented in the different levels of PIM activities. In the State, it happens from the articulation of different departments, and it also has the support of the Management Committee. The State, in turn, articulates with the municipalities through technical and financial cooperation. In the municipality, the intersectoral management is reaffirmed, since the technical coordination group must have representation of at least Health, Education and Social Assistance department professionals.

Likewise, the integration of the *Primeira Infância Melhor* actions with the existing services in the territory ratifies the intersectoriality advocated by the Program. At the same time as it identifies demands and activates the service network, also constantly referenced by other professionals to accompany families. Through this practice, PIM is defined as an integral care policy, promoting articulated action among very different areas. This articulation seeks to optimize human and financial resources, the non-dissociation of the different services, the qualification of communication, and especially the production of significant results for the development of pregnant women, children, and their families in situations of great risk and social vulnerability.

A Program geared towards integral care

Integral care, as a principle for *Primeira Infância Melhor,* refers to the understanding that the factors that interfere in a child's development are broad and span across different areas. Integrality is sustained and defended as a value for the practice of all actors involved in the management and execution of the Program. Bearing out its intersectorial character, PIM includes Primary Health Care, Basic Social Protection and Education.

Primeira Infância Melhor is one means of accessing the Unified Health System (SUS), through Primary Care[7], which functions as a filter capable of organizing the flow of services in healthcare networks, acting to

7 Primary Health Care is characterized by a set of actions, both individually and collectively, that include health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction, and health maintenance, seeking the development of integral care that impacts people's health and autonomy. It is the preferred contact of users, the main gateway, and the communication center with the entire Healthcare Network. (Federal Directive no. 2488, 2011).

prevent diseases and promote health, while simultaneously directing the most serious situations to higher and more complex levels of care (FIOCRUZ, 2017).

The PIM team connects with the Primary Health Care and Family Health Strategy Teams (ESF[8]), the Basic Health Unit - UBS[9] is also one of the strategic spaces for the Program. PIM Visitors and Community Health Worker - CHW[10], within their specific work roles, act as partners regarding the attention given to families. It should be noted that the purpose of the visits, their frequency, the care duration, and CHW and PIM Visitor attributions are differentiated, as shown in Table 1. The complementarity of these professionals is of fundamental importance for the quality of the service offered and the consequent impact on the lives of the beneficiaries. The CHW favor the integration of the PIM team with the community, as they also assist the active search for pregnant women and children.

Table 1 - Comparison regarding the operations of the Home Visitor and the Community Health Worker (CHW)

	PIM Visitor	Community Health Agent
Target-group	Families with pregnant women and children ages 0 to 6 with a status of risk and social vulnerability.	Families in a geographic base defined by a micro care area.
Objective	To guide families based on their culture and experience in order to **promote integral development of their children**, from gestation until right before they turn six years old.	To develop activities for disease prevention and health promotion through home or **community actions**, developed individually or collectively in conformity with SUS guidelines.
Supervision	Supervised by a **Monitor** and/or representatives of the Municipal Technical Group. Each Monitor (20h) is responsible for supervising up to 8 Visitors.	Supervised by the **nurse** from Family Health Strategy. Each nurse is responsible for orienting 12 CHWs.
Care ratio	Each Visitor cares for **up to 20 families.**	Each CHW cares for **up to 750 people.**
Care frequency	**Weekly** for each pregnant woman or child.	**Monthly** for each family.
Care duration	From 45 minutes to 1 hour.	Not specified.

Source: State Law 14.594/14; Federal Directive no. 2.488/11

8 The Family Health Strategy - ESF is considered by the Ministry of Health and managers as a strategy to expand, qualify, and consolidate Primary Care by favoring a reorientation of the work process with greater potential to increase the resolution and impact on the health situation of people and groups, in addition to providing an important cost-effectiveness ratio (Federal Directive No. 2.488, 2011).

9 The Basic Health Unit - UBS is the preferred contact of users, the main gateway, and the communication center with the entire Healthcare Network. It is located close to where people live, work, study, and live and, therefore, plays a central role in ensuring access to quality health care for the population (Ministry of Planning, 2017).

10 The Community Health Worker (CHW) is the professional responsible for health promotion and prevention, mapping and directing people to the health services (Ministry of Planning, 2017).

By working primarily on strengthening family ties and access to rights, PIM helps families to take the lead in caring for and protecting their children. The Program contributes to the prevention of situations of risk and vulnerability, as well as to the monitoring of problems already present in the family context, meeting the Basic Social Protection assumptions[11], which considers the ensuring of family rights as the focus of their actions. Working together with social protection teams seeks to strengthen families and develop their autonomy, supporting them to overcome any difficulties. The Social Assistance Reference Centers - CRAS[12] are the main articulators of joint actions with *Primeira Infância Melhor*.

The PIM contemplates education by promoting an expanded view on the constitution of the subjects, their needs, potentialities, and rights. The Program plays a crucial role in strengthening families to accompany the learning processes of their children, as well as contributing to their school readiness when they enter Basic Education[13]. PIM and the institutions of early childhood education are partners in the promotion of child development, since they use different methodologies to assist the same age group (zero to five years old[14]). Likewise, PIM is systematically linked to the local education system and acts to encourage adult empowerment to care for, educate, and protect themselves and their children, thus contributing to the re-entry of parents and/or caregivers in the education system, to complement the years of study.

Intervention Technology

Home visitation and playfulness are intervention technologies used by *Primeira Infância Melhor*. These technologies make it possible to bring the Program closer to the realities assissted, favoring a more precise recognition of the characteristics, potentialities, and needs in each context, resulting in unique proposals for intervention pertinent to each reality.

The home visit prescribes the valorization of the family, the home, and the community as privileged places for the promotion of health and well-being (Drügg; Verch & Fontoura, 2016). The activity carried out directly in the homes allows the PIM team to know the structure and dynamics of the family, identifying potentialities and risk factors, as well as the active participation of the family in its broad development process.

PIM home visitation considers the following aspects: broad and semi-structured intervention curriculum; unique care plan; home visit script; intensity and duration of visits; qualified listening and outlook; support materials; training of the professionals involved; supervision process; and field monitoring.

Playfulness is the main connection trend for PIM with and among families. This has come to be understood as an intervention technology, since it favors the positive trend in working with families, and it understands that, beyond fragilities, it is fundamental to look at their

11 Basic Social Protection is the set of services, programs, projects, and benefits of social assistance. It is aimed at the population living in situations of social vulnerability due to poverty, deprivation - lack of income, precarious or no access to public services, among others - and/or weakening of affectional bonds - relational and social belonging - age, ethnic, gender or disability discrimination, among others (Federal Law No. 8.742, 1993).

12 CRAS represents the main local physical structure for Basic Social Protection. It plays a central role in the territory where it is located, having the exclusive function to publicly offer social work with families through the service of integral protection and care to families, and territorial management of the social assistance network (Technical Guidelines: CRAS, 2009).

13 Basic Education is made up of three stages: Early childhood education - serves children from zero to six years old. Elementary School - with a minimum duration of nine years. High School - it is the final stage of basic education, with a minimum duration of three years. It can be offered along with professional education (Federal law no. 9.394, 1996).

14 5 years, 11 months and 29 days.

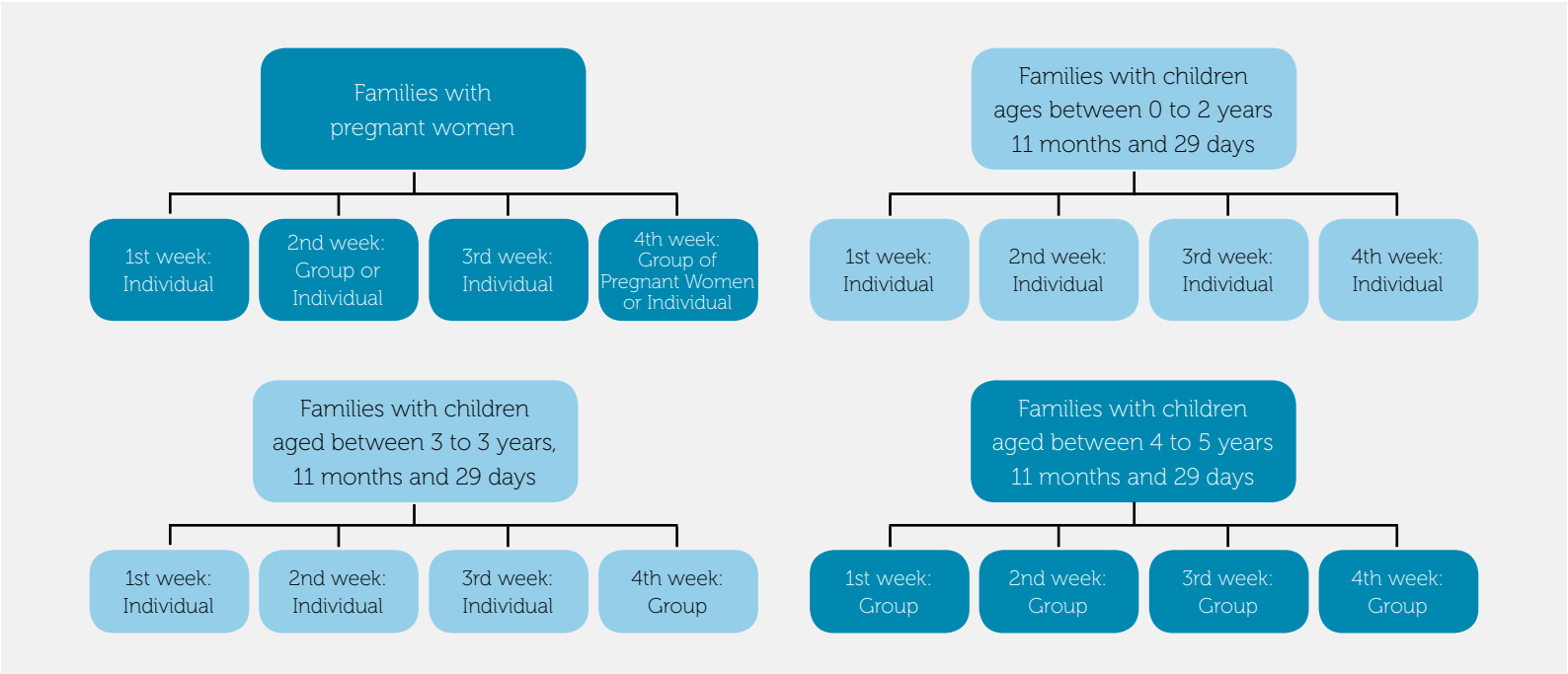
potential, valuing their self-esteem, creativity, life histories, desires, etc.

Playful intervention makes it possible, even momentarily, to build favourable environments to early childhood development. In this context, not only the act of play does impact the child but also their caregivers and the professionals involved. Playing is one of the primary means by which the child understands, relates, and communicates with the world (Vygotsky, 1988). For the adult, the playfull PIM experiences allow the strengthening of affectional bonds, moments of pleasure, recall, and re-signification of childhood experiences, as well as the possibility of overcoming difficulties in a more optimistic and spontaneous way. Likewise, playfulness plays a fundamental role for the professionals involved in PIM, especially the Visitor, who has to deal with an intense load of demands from the families, and finds greater lightness to adequately carry out their work through this technology.

Care Modalities: interventions along with families

Care Modalities is the name given by *Primeira Infância Melhor* to define the care provided to families. It is divided into: Individual Attention Modality and Group Attention Modality, which are for different age groups, as shown in figure 2.

Figure 2 - Care Modalities



Source: PIM Official Memo no. 01, 2016

In families with pregnant women the care is individual and follows a weekly basis. They also participate in the pregnant women's group organized by the service network in the territory, always with the participation of the PIM team. Also, respecting the needs of

each municipality, the pregnant women can occasionally participate in a Group Modality, under PIM coordination and with a previous appointment (State Health Department, 2013).

In families with children from 0 to 3 years of age, the care is individual, weekly, and through home visitation. As they turn three, they begin to have a monthly-group care in collective community spaces in order to start the socialization process, once it is from the age of four that they will receive care exclusively through Group Modality[15] (PIM Official Memo no. 01, 2016).

In addition to the Care Modalities, the Program advocates the implementation of Follow-up Visits, which sporadically take place, according to the needs of each family. The visits are to strengthen the orientations and to clarify doubts and to supplement stages of the monitoring process and the child development assessment.

The execution of the Care Modality process requires different stages. Initially, the **Care Modality Plan**[16] is carried out where the Visitor plans the home visit, defines what activities will be carried out, which resources are needed and which aspects of the development stage will be worked out, following the unique care plan for the pregnant woman or child and its family. This process takes place with the support and supervision of the Monitor and/or representatives of the Municipal Technical Group and support of the Program materials, such as Orientation Guides and the Making Art Collection with PIM. Once the plan is validated, the Visitor performs the home visit or the group activity, respecting the three specific moments of the methodology.

15 By 2016, when they were three years old, children and their families began to be cared for in the Group Care Modality, as it aimes the process of socialization and interaction with the community. In view of the guidelines for all children that are four years old to be enrolled in early childhood education schools, in compliance with the National Education Plan, it was necessary for PIM to adjust its form of care, expanding by twelve months the possibility of individual home care. This flexibility of methodology was due to the fact that many children cared for in the Group Care Modality entered formal education.

16 All the bold names refer to specific PIM instruments, developed by the State Technical Group. Internal, unpublished documents.

Table 2 - Home visit or group activity moment

1	At first, the Visitor offers a space for welcoming and listening to the family and verifies how they are that day. Together they resume and evaluate the activities carried out during the week and discuss the proposal of playful activity for the day.The Visitor presents these objectives regarding the gestational period or child development and agrees what the activity for the family will be. The activities and guidelines are directed to the caregivers so that they develop the proposed work with their children, allowing the consolidation of the family bond and the commitment of parents and/or caregivers to their children. In the case of pregnant women, the guidelines will be directed to her and her family members.
2	The second point is the execution of the play activity by the family, with mediation and support from the Visitor. This is the moment in which parents and/or caregivers exercise a leading role in the care and attention of their children, where the potentialities are valued and there is room for everyone to express their creativity, in addition to strengthening the positive intrafamily interaction.
3	In the third and final point there is a joint evaluation of the activity in order to identify progress and difficulties; reinforce the importance of the issues addressed, clarify doubts, and especially increase the knowledge and attention of parents and/or caregivers regarding the development of their children, or for the pregnant woman regarding herself and her baby. Finally, the Visitor reinforces the importance of continuity for the activities proposed that week.

The activities carried out in the Care Modalities use play as an intervention technology because this is a strategy that strengthens the knowledge building and care practices that are favorable to the integral development of early childhood. Playfulness encourages the involvement of families and their connection to the child's universe, which is often unknown or forgotten by adults. In this sense, it revitalizes expressions of affection, creativity, and fantasy, and contributes to the establishment of active and safe participation by families. In the Care Modalities, suggestions and/or games are proposed to contemplate the phases of the child's development or the gestational period of each beneficiary. One example is the use of the "box of feelings", through which the pregnant woman and her family are invited to record through drawings, words, or magazine clippings, their expectations and emotions about pregnancy; the "pregnant woman's diary", carried out in different municipalities is more significant, especially for women deprived of their freedom, who can record, with photos and reports, the whole context of gestation in prison; the making of toys/games with materials available at home, and the construction of a "toy box" that inserts play into family routines; shantala massages, strengthening the caregiver/baby bond; the revitalization of nursery rhymes , as a stimulus to language and socialization; among others.

Seeking quality of care for families, after the home visit and/or the group activity, the Visitor reflects on the interventions of the week, using them as a basis for planning the activity of the following week. In addition, he analyzes with the Monitor and representatives of the Municipal Technical Group, under supervision, important aspects that have arisen during the visit, seeking to optimize the demands of the family, as well as necessary referrals to the service network. The organization of supervisory spaces favors listening to the Visitor and can contribute to reflections, questions, and the construction of points of view composed by different professionals. (Drügg; Verch & Fontoura, 2016).

CHAPTER 2

STRUCTURE AND OPERATIONS

The technical and methodological structure of *Primeira Infância Melhor* is organized in order to ensure adequate operations to reach the Program's objectives. Therefore, even though there is an existing structure, the PIM methodology respects and adapts to the characteristics of each territory. This requires consistent, comprehensive, and constant training for the Program's entire team. Since its focus is the care for families in the situation of risk and social vulnerability in Rio Grande do Sul state, the judicious selection of the beneficiaries is another fundamental aspect for PIM execution. Likewise, it is necessary to have a budget that considers the financial resources for the sustainability of this public policy.

Human Resources

Intersectoriality is a PIM hallmark and is also reflected in the human resources that make up the technical structures at both municipal and state levels. At the state level, *Primeira Infância Melhor* is coordinated by the Health Department with the support of the Education, Culture, Social Development, Labor, Justice, and Human Rights Departments, and the Office of Social Policies.

In addition to the action mechanisms of the departments, this structure has a Management Committee with political-institutional attributions, and it is composed by representatives from the aforementioned departments. This committee seeks to promote debates and reflections aimed at evaluating challenges and proposing practical measures to qualify and expand the Program. It is also an opportunity to promote good practices for early childhood development and promotion of PIM through advocacy (FGV, 2014b).

Also at the state level, within the scope of the Health Department, there is the State Technical Group (GTE), which is the Program's management group. It is composed by a multidisciplinary team of specialists geographically distributed among healthcare macro-regions. Each GTE member assists an average of thirty municipalities. The main task of these professionals, according to State Directive no. 569/12, is to elaborate strategies for implantation, implementation, expansion, monitoring, and evaluation of *Primeira Infância Melhor*. Also, GTE develops instruments and tools; it trains and advises the municipal teams; it monitors and evaluates the actions and results achieved by the municipalities; it mobilizes and articulates the state and national network for early childhood; it promotes events, and supports policies initiatives or programs initiatives for early childhood in different Brazilian states/municipalities.

GTE also includes the representatives of the Regional Health Offices - CRS and Regional Education Offices - CRE, which are located in strategic points throughout the state. They share the task of supporting the coordination, orientation, and supervision processes for PIM actions in the municipalities under their jurisdiction.

At the municipal level, the technical structure is made up of the Municipal Technical Group, Monitors, and Visitors. The Municipal Technical Group - GTM is made up of degreed professionals from the Health, Education, and Social Assistance departments. This group fulfills a workload of at least 10 hours per week and holds the responsibility of implanting, managing, monitoring and evaluating PIM in the municipality. GTM also takes the mission of selecting Monitors and Visitors; carrying out initial and continuing training; systematically supervising the Monitor and the Visitor; promoting continuing education; selecting the care areas; supporting the active search of families; managing the PIM Information System; articulating the service network; sensitizing managers; facilitating the GTE technical support visits; participating in the training promoted by GTE and mobilizing the formation of the Municipal Committee for Early Childhood (State Ordinance no. 578, 2013).

The Monitor is the interlocutor between GTM and the Visitor. It is the professional with a completed or ongoing degree who is responsible for orienting, accompanying, monitoring, and evaluating the work of up to eight Visitors, as well as supporting actions developed by GTM, fulfilling a minimum workload of 20 hours per week. It also plays the role of the articulator with the service networks in the territories where it operates.

The Visitor is the fundamental member of this structure as it is the direct link with the families. It is the one who better understands the dynamics and parental interactions, and is the co-responsible agent for strengthening family competencies. The Vistitor's functions

are: plan, execute, and evaluate the Care Modalities; notify the Monitor and GTM regarding situations identified in the families; monitor the outcomes of PIM interventions; participate in the weekly supervision and training carried out by GTM and the Monitor; sensitize families and the community, as well as create activities that are integrated with other agents in the territory. This professional must have a high school diploma, fulfilling a variable hourly load between 20, 30 or 40 hours per week, according to hiring format of each municipality (State Law no. 14.594, 2014).

PIM experience confirms that this technical structure is necessary, and is one of the key points of the Program. As for PIM objectives, this human resources structure favors an adequate response to the needs of families. There is thus a dynamic and permanent process, like a gear in which all parts are interdependent for the proper functioning of the system.

Visitor Profile

The Visitor is responsible for home and community care for families benefiting from *Primeira Infância Melhor*. They are directly responsible for supporting families to strengthen their skills in caring, educating, and protecting their children (Schneider *et al*., 2016). Considering the relevance of their performance, it is necessary to select professionals with a profile that responds to the day to day demands of PIM efforts.

The selection of the Visitor is the responsibility of the municipal team together with the support from GTE. Therefore, there are criteria regarding minimum level of education: high school diploma and/or ongoing undergraduate studies, preferably in the areas of education, health, or social service, plus an introductory course conducted by GTM with a minimum duration of 60 hours. Under exceptional circumstances and with a favorable opinion from GTE, someone with only elementary education is admitted for the position of Visitor, along with a specific introductory course held by GTM with minimum duration of 120 hours (State Law no. 14.597, 2014). In addition, each municipality must establish, in its own notice, any other selection criteria, respecting the peculiarities of each territory and the legal guidelines of the local administration.

According to the **Orientation Guide for Visitor Initial Training**, it is expected that the professionals selected for the post of Visitor will have the following skills: value the potential and the leading role of families to overcome their vulnerabilities; have a broad view regarding the family/community contexts and their dynamics; offer orientation and activities that are part of a comprehensive curriculum, and use playfulness as a strategy to strengthen families.

These skills should also serve as a basis for the processes of Visitor monitoring and training. For this purpose, the municipal team should organize systematic supervision and support routines with the purpose of enhancing the skills of this professional, and assisting in the difficulties they face in their daily work. That way, the Visitor should feel empowered to perform his duties, as described in State Ordinance No. 578/2013:

- Create integrated actions contributing to the qualification of the work processes and access for the families to the policies developed in the territory;
- Create awareness among the families and communities regarding PIM objectives;
- Promote the integral development of the child, observing four dimensions: socio-emotional, motor, language/ communication, and cognitive;
- Plan and execute care, in accordance with PIM methodology, considering the family,

community, and cultural context, with the support of service networks;

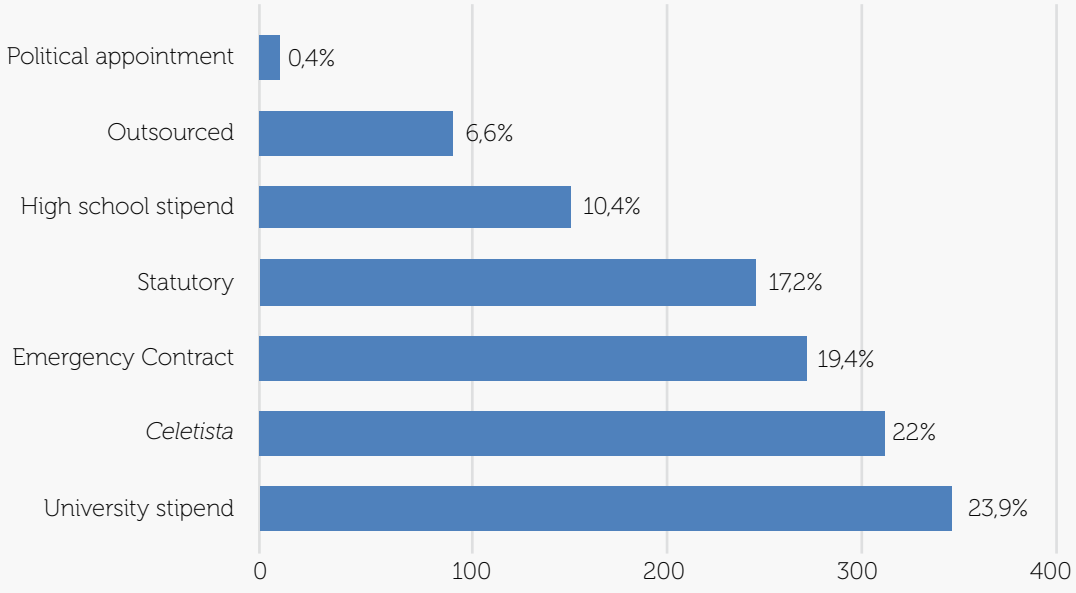
- Strengthen competencies among families for the education and care of their children;
- Monitor the results of PIM intervention in relation to the development of families, pregnant women, and children;
- Report situations identified in the care routine that may affect the healthy development of beneficiaries.

The payment of the Visitor's compensation, including social charges and travel, are the municipality's responsibility. However, the State government transfers a monthly amount to the municipality based on the proportionality among the number of Active Visitors and the workload laid down in the contract. These funds are not characterized as the salary of the Visitor, but may be used for the payment or supplementation of their compensation. According to State Directive no. 578/13, Visitors may have different workloads. Thus, the number of families assisted by the Visitor also occurs in a differentiated way. Professionals who have a weekly workload of 20 hours should assist up to 14 families, the ones who work 30 hours per week should assist up to 17 families, and those with a 40-hour weekly journey should assist a maximum of 20 families.

Having presented the attributions, skills, and profile expected in the Visitor's selection process, it is necessary to reflect on the current situation of the professionals who work in the municipalities where PIM has been implanted, since some challenges are still faced, especially regarding the Visitor hiring format, while simultaneously considering the level of education of those who have been hired.

According to Figure 3, of the 1,404 active Visitors in the SisiPIM in December 2016, 39.2% have a statutory or *celetista* agreement; 34.2% are stipend recipients, and 26% use other hiring formats.

Figure 3 - Employment relationship with the Visitor



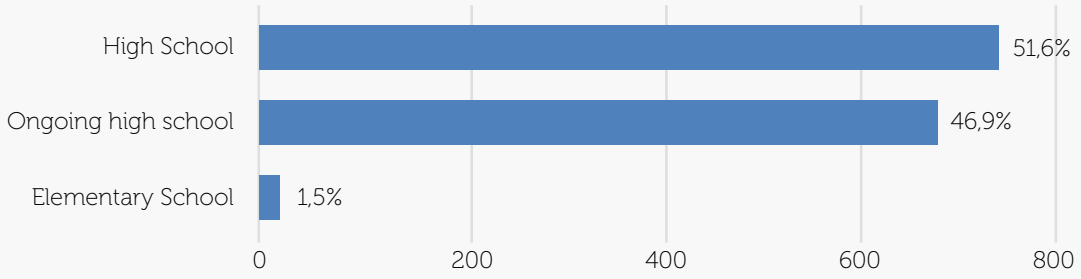
Source: SisPIM - December 2016

The *celetista* or statutory Visitors are part of the staff of the municipality and, therefore, the payment of social charges is the municipality's duty. Among the benefits of these kinds of contract is the maintenance of the professionals within the team for a longer time, facilitating the knowledge accumulation and the improvement of practices that are required by PIM. In addition, these types of contracts support the Political Appointment Program for filling the vacancies. For the Visitor, it represents the guarantee of benefits related to labor rights, such as vacations, retirement, 13th salary, among others. However, there is the risk of hiring professionals without the desired profile. For this purpose, some mechanisms contribute to overcome this challenge, such as the careful preparation of the selection process, drawing up a suitable selection notice as well as evaluations for the inicial contract period, which allows, for instance, potential removal of the candidates.

In the hiring of stipend beneficiaries, whether they are university or high school students, the administrative processes for Visitor payment are simpler. This type of hiring has as restriction the maintenance of the professional for only two years at work, which is the maximum allowed length of the partnership between school/university and the municipality. Turnover is a challenge for municipal teams, as they need to devise strategies to ensure the maintenance of the bond between families and the Program. The benefits of this hiring format are: greater technical knowledge in a field related to the Program; a desire to get practical experience in the content addressed by the academic institution ; more academic production on the subject; closer ties with academia regarding public policy for early childhood; supervision of the Visitors by academics, and professional enrichment of the student.

Regarding the educational level of the Visitor, of a total of 1,404 Visitors registered in SisPIM in 2016, 21 had only primary education, 725 had high school degrees, and 658 are attending higher education institutions (figure 4). This means that more than 98% of Visitors have 11 years or more of training, which is considered by several authors to be desirable under a high quality scenario (Leia *et al.,* 2016).

Figure 4 - Visitors' level of education



Source: SisPIM - December 2016

Training of technicians to address the methodology's complexities

The complexity of the work carried out by *Primeira Infância Melhor* assumes that the professionals involved are constantly training to ensure the quality of the actions performed. In this context, the training of professionals is understood as a continuous, participatory, and critical-reflective educational process that allows the construction of technical skills for the people involved in the Program. Initial and continuing training modalities are carried out, as well as their constant maintenance through permanent education, always in accordance with the guidelines of healthcare, education, and social development policies.

All professionals who join the PIM technical team need to take the Initial Training, which has an introductory and awareness-raising feature. The Initial Training stands out according to two different groups: GTM and Monitor Initial Training, and Visitor Initial Training.

The State Technical Group - GTE is responsible for the planning and execution of the GTM and Monitor Initial Training, in which managers and professionals of the service network also participate. This is done quarterly and has a minimum workload of 24 hours. The GTE representatives, Regional Education and Health Offices, as well as specialists and professionals in the service network participate as trainers (State Law no. 14.594, 2014).

The **GTM and Monitor Initial Training** includes the following themes: arguments for investing in early childhood, PIM public policy; profile, functions, and tasks of the technical teams; financial resources and ways of hiring Visitors; early childhood situation in the municipality; census and mapping of areas and families; action plan for the implantation process; characterization and diagnosis; support materials; Care Modalities; monitoring the integral development of children, and the PIM Information System. The methodology used presupposes the active participation of all involved, considering the knowledge that comes from their experience, seeking to stimulate discussion and build solutions as a team.

In the municipality, GTM is responsible for replicating acquired knowledge to the team. It is the responsibility of the Municipal Technical Group to plan and execute the Visitor Initial Training according to the matrix structured by the State Technical Group. For this purpose, it has the support of local service network professionals and GTE representatives. It is important to emphasize that these training courses are organized respecting the singularities of the territory, but they must maintain the sequence of the following thematic axes: human development and early childhood; play; family; community; home visitation; methodology; network and territory; management; PIM playfulness, and practical activities in the communities.

The Visitor Initial Training can vary according to the type of selection of the professionals. There are two versions of this process: the pre-selection version, recommended when the initial training includes the selection process (stipend recipients and *celetistas*); and the post-selection version, recommended when the initial training takes place after hiring the Visitor (civil service exam and public employment). Both versions follow the same thematic logic and must be completed within the period of 30 days after the Visitor is hired. The minimum workload is 60 hours a week, and in the pre-selection version, the initial 20 hours are eliminatory in nature, and are part of the selection process.

Since the themes are not exhausted in initial training, the complexity of the methodology and the challenge of working with vulnerable families from an intersectoral point of view, it is necessary to invest in the continual training of the professionals that make up the PIM

team. This training aims to broaden knowledge about specific topics and is periodically carried out according to the daily demands of the Program.

Based on the questions raised in the team meetings, supervision of the cases, and other situations of follow-up in the Program, there are environments organized for the continuous training, they may fit in the form of immersion, participation in events, meetings with the service network, and the weekly permanent education processes.

Budget and financial resources for the Program's sustainability

The attention to the first years of life is one of the best investments a country can make. According to Heckman (2006[17], 2010) serious social and economic problems often stem from the low capacity or competence of the population. Early intervention actions may help increase schooling, reduce crime, increase productive capacity, and reduce the number of teen pregnancies. These interventions produce high rates of financial return, as well as a significant cost-effectiveness ratio (Bernardes, 2010). Thus, it is important to emphasize that Berlinski & Schady (2015) point out that of nine countries in Latin America and the Caribbean, Brazil is the second country with the largest public investment policies benefiting early childhood. Annual public expenditures are USD 641 per child in the age range from zero to five years of age, the equivalent of 0.5% of the Brazilian GDP. However, this investment is still lower than the OECD countries (0.7% of GDP) and the Nordic countries (1% of GDP).

In Rio Grande do Sul, of the State Health Department 2016 annual budget BRL 20 million is allocated to the maintenance of PIM, representing 0.88% of the department's budget. This amount is used mainly for the payment of the financial transfer to the municipalities that have implanted PIM, but also for the human resources of the State Technical Group, training and events, uniforms and support materials sent to municipal teams, and advocacy actions. The financial sustainability of *Primeira Infância Melhor* depends on joint action between the State and municipalities.

The monthly financial transfer from the State to the municipalities is based on the proportionality between the number of active Visitors in the municipality and the respective workload laid down in the contract. According to Table 3, this rationale is due to the fact that the municipalities have different ways of hiring Visitors and have the autonomy to work with different weekly workloads.

Table 3 - Monthly financial transfer from the State per number of Visitors

Visitor work load	Monthly financial transfer per no. of Visitors
20 hours a week	BRL 500.00
30 hours a week	BRL 750.00
40 hours a week	BRL 1,000.00

Source: State Directive no. 578/13

17 Report given at the 1st Early Childhood International Symposium, PUCRS, 2006.

These funds should be applied to PIM related actions and for supplementing the specific programs in the area of Primary Care, and may be used in municipal costs for operating and/or capital expenses. In addition, the regular transfer of the resource is conditional, requiring the effective execution of the *Primeira Infância Melhor* Program, as well as the systematic updating of SisPIM.

It is the municipality's responsibility to supplement the amount transferee by the State for the sustainability of the Program in the territory. Considering PIM's proposal to ensure shared management of their responsibilities, respecting the interdependence and horizontality of their actions and preserving the institutional identity of the municipal departments involved, it is advised that the Departments of Education, Health, and Social Assistance reserve specific funds in their annual budgets for *Primeira Infância Melhor* activities (State Directive No. 578, 2013). This amount is used to cover costs such as: contracting GTM, Monitors, and Visitors; the physical structure for team work; resources and support materials for the development of Care Modalities; training; travel; execution of events; etc.

Analyzing the investment made by the State in 2016, divided by the number of pregnant women/children receiving PIM care, there is a per capita state investment of BRL 36.66 equivalent to USD 11.86 per month[18]. On the other hand, the municipal investment, accounting for expenses with the municipal GTM team, Monitors, Visitors and Data Entry personnel, the physical structure, materials and transportation, the average amount per pregnant woman/child is BRL 37.23, the equivalent of USD 12.04 per month. Thus, the total investment made by the State and the municipality per pregnant woman/child receiving PIM care is an average of BRL 73.89, the equivalent of USD 23.90 per month[19] (USD 286.8 per year). The cost-effectiveness ratio is a prime factor in the allocation of public resources in public policies for early childhood. According to a survey conducted by the Inter-American Development Bank (IDB), the annual cost per child in home visiting programs[20] in Chile is USD 871, USD 741 in Colombia, and USD 515 in Guatemala (Armendáriz *et al*., 2016). Measuring the real cost of home visitation programs is challenging, since they contemplate different inputs, depending on the reality of each territory. However, it is a necessary calculation to encourage investment actions during the first years of life. *Primeira Infância Melhor* has the lowest annual cost per child (USD 289). Considering that the program's impact goes beyond the pregnant woman/child being cared for, as it strengthens other family members, the total cost of PIM could be even lower.

From adhesion to implementation: the Program's operational dynamic

Primeira Infância Melhor is able to be sustained as a permanent policy due to the consistency and structure of its methodology . There is a script for activities that provide a foundation for the Program's adhesion, implantation, and implementation process stages. These stages are managed and monitored by the State Technical Group along with the Municipal Technical Group.

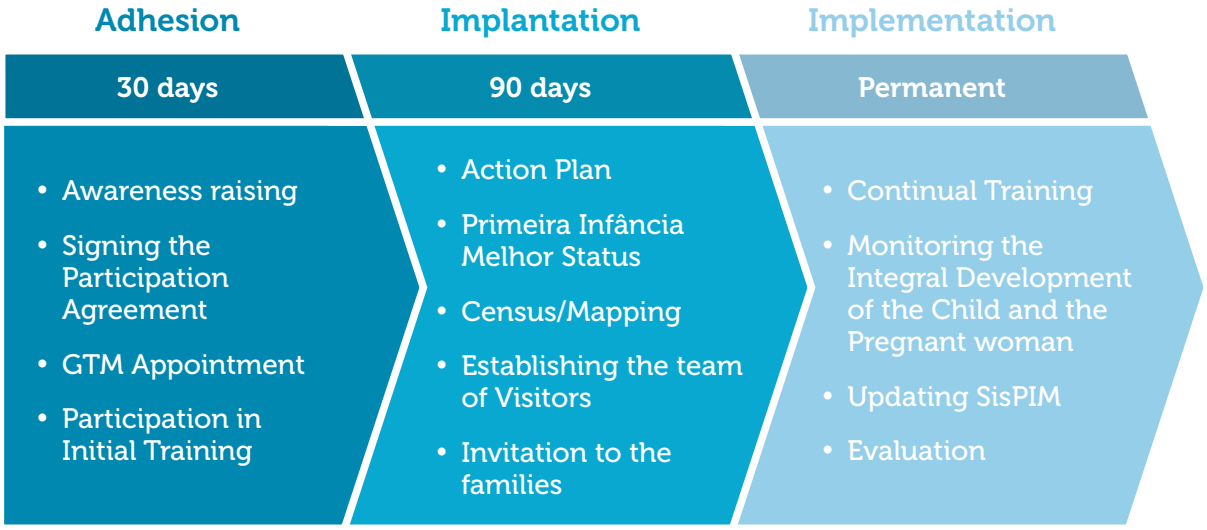
Adhesion to the Program is done through the awareness-raising towards the mayors and the departments, which is made by the representatives of the state departments, the

18 USD 1.00 equivalent to BRL 3.08 on the calculation date.

19 The amounts were calculated based on the following inputs: human resources; social charges; infrastructure; materials and transportation.

20 The values were calculated based on the following inputs: human resources; infrastructure; nutrition, equipment, and materials; and expenses with specific training and supervision.

Table 4 - Program Operations



Management Comittee, and the municipality's free initiative. Once interest between both parties is established, the mayor signs the **Participation Agreement**, which formalizes the initiative to implement PIM in the municipality, and he immediately appoints the Municipal Technical Group. The appointed GTM will be trained by the GTE in up to 30 days so that it can continue all the processes in the municipal realm. It is, then, time to raise awareness among the leaderships in the territory and to start the study regarding the hiring format of the Monitors and Visitors (Bernardes, 2010).

PIM implantation in the municipality is divided into three phases. During the first phase GTM should raise awareness among the managers involved with the Program; define the number and format of Visitors hires; develop the **Plan of Action**, analyze the **Early Childhood Status in the Municipality**; elect the community or communities best suited for the implantation, and prepare the Census/Mapping of the families. This stage must be carried out within the maximum period of 30 days from the end of the GTM and Monitor Initial Training.

The **Early Childhood Status in the Municipality** contextualizes the structural and social reality and the actions directed to the first years of life, as it aims to identify the reality of the different communities, to map the existing services, and to identify the potential needs of the coverage of the early childhood care as a result of the organization and articulation with the service network. The information required to fill out this document is obtained through official data sources and is normally used to assist with respective municipal plans. The **Census/ Mapping** process transforms the information obtained in the previous process into a map that reflects the distribution of Visitors and resources available in the geographical area, in order to optimize services and family access.

The second phase of the implantation is basically the formation of the Visitor team, and should take place within 60 days after the Initial Training for GTM and Monitors. This phase includes the updating of the Action Plan; preparation of the **Visitor Initial Training Plan**; preparation and dissemination of the public selection notice; selection of the Visitors, and execution of the Visitor Initial Training. After selecting the Visitors, the municipality informs the State the number of Visitors hired and their respective workload. Then, the process of registering municipal data in the PIM Information System begins.

The third and final phase of the implantation takes place within a maximum period of 90 days after the Initial Training for GTM and Monitors, when work with the families begins.

This phase includes the following actions: PIM awareness and dissemination in the territory; GTM participation in municipal councils and/or committees focused on early childhood; invitation to families to join PIM; application of the **Characterization and Diagnosis** form, and beginning of intervention with families.

The Characterization and Diagnosis instrument is filled out by the Visitor along with the families that joined the Program and is one of five characterization forms: the neighborhood or community, the family, the pregnant woman, the child, and the Initial Diagnosis of Child Development (Baseline). This instrument allows the visualization of the current situation of the family and the stage of development of the pregnant woman and/or the child upon entering PIM. Only after this characterization do the Care Modalities begin.

From there, the implementation stage begins, with no allotted deadline, since it includes the continuity and improvement of *Primeira Infância Melhor* in the municipality. At this stage, according to the program's development in the municipality, there should be actions such as: planning and execution of Continual Training for Visitors, Monitors, GTM and other network professionals should occur; **Monitoring of Integral Child Development**; systematic update of the PIM Information System; Program evaluations; request for approval of the financial resources to **Expand the Number of Visitors**; request for **Disabling Visitors**; request for **Temporary Suspension of the Program**, and request to **Disable the Program**. Up to the present day, 52 districts have deactivated PIM (SisPIM, 2016). However, it is important to note that such deactivations may be seasonal, since it is common for districts to deactivate the Program and reactivate it after a period of political and/or administrative rearrangement.

Beneficiary selection process

The process of selecting the beneficiaries of the *Primeira Infância Melhor* is carried out in three specific stages: the selection of the municipality to be implanted, the selection of the area or areas to be benefited, and the selection of the families receiving care.

To select the municipality there are two paths: the interest of the municipal manager in implementing the Program or a study carried out by GTE of state and municipal indicators which reveal cities with higher levels of vulnerability in the state, according to the criteria suggested in table 5. Once these municipalities have been defined, GTE members raise awareness among municipal managers to join PIM.

When the municipality adheres, the care area "or areas" will be selected, based on the results obtained in the study of the **Early Childhood Situation in the Municipality**. To do so, there is an analysis of data such as: coverage of families included in income transfer programs and/or profiles that fit into the Bolsa Família system; child education coverage; precariousness or lack of services, among others (Table 5).

Once the area or areas are defined with the help of the professionals from the service network, the families with pregnant women and children from zero to six years old are mapped, and those that meet the risk and social vulnerability criteria are identified as priorities by the Program (Table 5). From that point on, the process begins to raise awareness among the families in order to take part in PIM. In municipalities where the Program has been in place for a longer time, families can also be referred to care through professionals in the service network. In places where PIM is already inserted in the culture of the territory, it is often the families themselves that indicate or request participation, which does not eliminate the need to evaluate whether they fit into the family selection criteria defined in the methodology.

Table 5 - Suggested criteria for the selection of municipalities, areas, and families

Priority criteria for the selection of municipalities

Lower GDP per capita
Human Development Index - HDI
Coverage for monitoring the conditional health factors of the Bolsa Família Program
Maternal/infant mortality rate
Mortality rate for women in fertile age investigated
Rate of vaccines of the basic vaccination calendar for children with vaccine coverage reached
Poverty concentration
Teen pregnancy
Population with some type of disability
Early childhood education coverage

Criteria suggested for area selection

Number of pregnant women and children between zero and six years of age
Coverage for families included in income transfer programs and/or with the Bolsa Família profile
Infant morbidity and mortality
Early childhood education coverage
Urban infrastructure
Rates of violence/drug addiction
Precarious or nonexistent services
Rural or urban areas that are hard to access, as well as settlements and specific or traditional communities

Suggested criteria for family selection

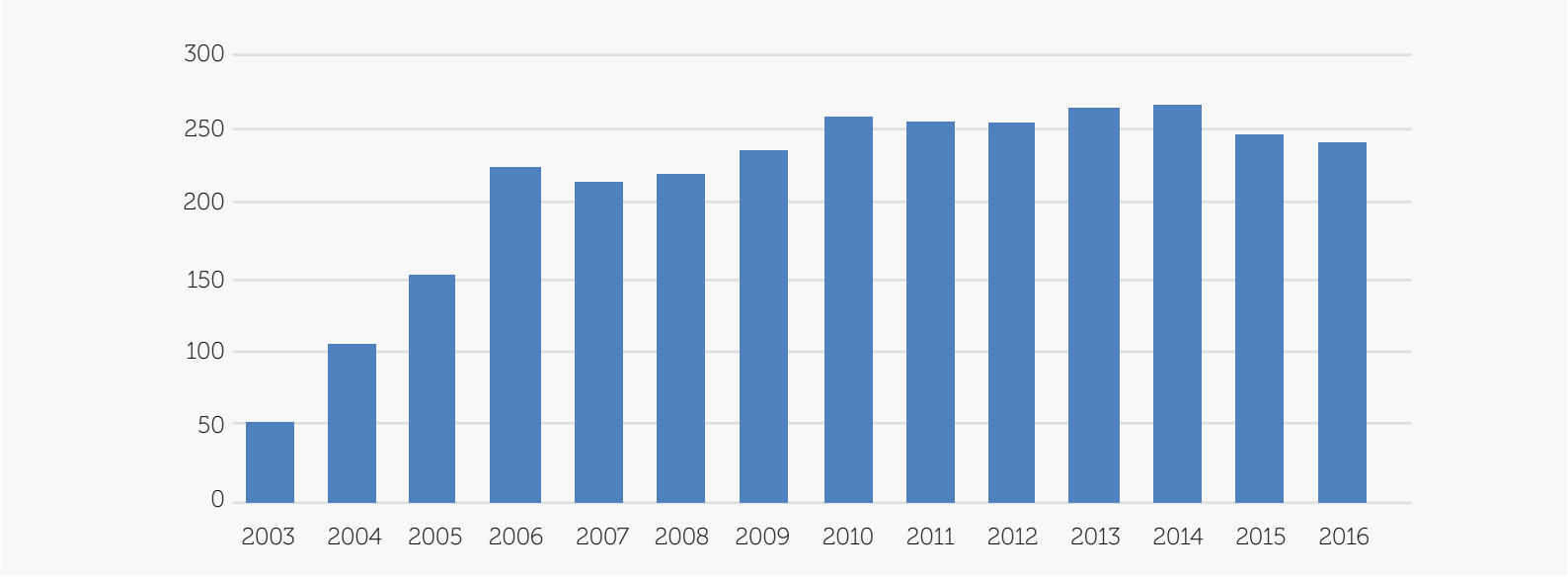
Inclusion in income transfer programs and/or with the Bolsa Família profile
Family income per capita
Living conditions
Domicile density
Teen or high risk pregnancies
Infant morbidity and mortality
Children with more than one hospitalization during the first year of life
Mothers diagnosed with post-partum depression
Families with caregivers, pregnant women, and/or children with disabilities
Alcohol or drug abuse
Family member with specialized care and/or psychiatric treatment
Illiteracy or poor education of the mother or main caregiver
Children not inserted into the formal education network
Domestic violence
Incarcerated family member

Source: Adapted from the GTM, Monitor, and Visitor Guide, 2007

Historic evolution and PIM beneficiaries profile

Throughout the fourteen-year history of *Primeira Infância Melhor*, the coverage of benefiting municipalities, families, pregnant women, and child has undergone changes that are normal for any public policy, with times of full expansion and others of decline (Figure 5), which are influenced by legal, economic, political, administrative and social issues. 2006 was shown to be an important year for PIM history, which was the peak of the implantation increase (73 municipalities[21]), such fact has been influenced by the legitimacy of the Program through State Law no. 12.555/2006. From 2009 to 2010, due to the influence of State Directive No. 78/2008, which increased the amount of funding from BRL 500.00 to BRL 1,000.00 for the municipalities that implanted the program in areas with high rates of violence, there was an increase of 22 municipalities. But the period between 2014 and 2016, there were 25 deactivations, reflecting the economic crisis faced by the State of Rio Grande do Sul, with an impact on the maintenance of the transfer of financial resources for co-financed policies and compliance with the provisions of the Fiscal Responsibility Law No. 101, 2000)[22]. These are factors that also impact the reduction of beneficiaries and the capacity to expand coverage.

Figure 5 - Historical series of certified municipalities



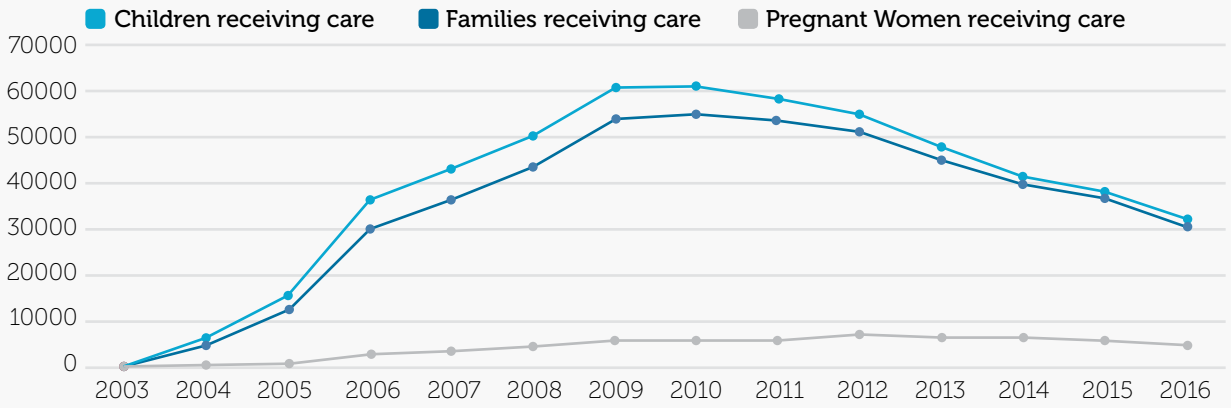
Source: SisPIM, 2016

The historical series of families, children and pregnant women cared for (Figure 6) shows the decrease in the number of children who benefited since 2010. As for from 2014 on, this fact can be explained by the changes in Brazilian legislation, which made it compulsory to enroll children in school from their four years of age on and the expansion of daycare coverage. Regarding the number of pregnant women cared for, it follows the same growth rate as the number of children cared for, although the variations are less pronounced.

21 In total RS has 497 municipalities.

22 Establishes, in a national regime, parameters to be followed regarding the public expenditure of each Brazilian federal entity. The budgetary restrictions seek to preserve the fiscal situation of the federal entities, according to their annual balance sheets, with the objective of guaranteeing the financial health of states and municipalities, the application of resources in the appropriate fields and a good administrative legacy for future managers (Complementary Law No. 101, 2000).

Figure 6 - Historical series of families, children, and pregnant women receiving care



Source: SisPIM, 2016

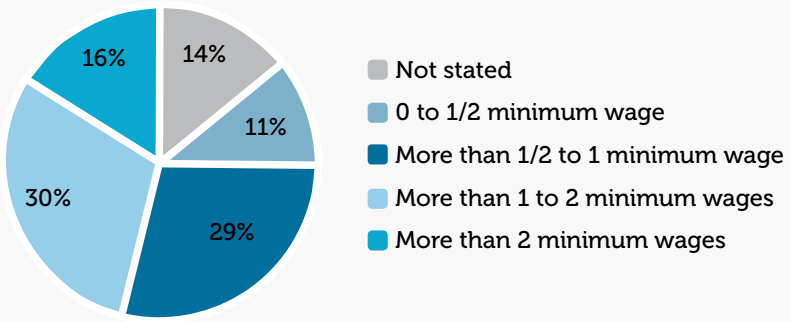
Communities receiving care

Of the communities that received PIM care in 2016, 40% are located in rural areas and 60% in urban areas. PIM is present in 19 *quilombola* communities, representing 10% of the state's total *quilombos* and in 10 indigenous communities, representing 8% of those communities (INCRA, 2013; SESAI, 2015; SisPIM, 2016). Among the specific communities, it is worth mentioning that in 2016, *Primeira Infância Melhor* provided care for around 100 incarcerated women, among pregnant women and mothers.

Beneficiary families

Of the total families receiving PIM care in 2016, 11% have a family income of up to 1/2 of a minimum wage, 29% between ½ to 1 minimum wage, 30% between 1 and 2 minimum wages, 11% of 2 to 3 minimum wages, 5% more than 3 minimum wages, and 14% unidentified (SisPIM, 2016). It must be emphasized that 53% of fathers are responsible for the economic maintenance of the beneficiary families. Of these, 30% are beneficiaries of the Bolsa Família Program - PBF.

Figure 7 - Family Income



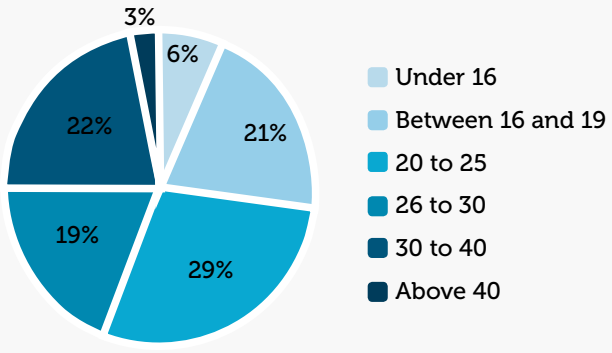
Source: SisPIM - December 2016

Beneficiary pregnant women

Regarding the race/color of pregnant women attended in 2016, 75% declared themselves white; 22% brown or black; 0.8%, yellow or indigenous, and the others did not specify. Regarding marital status, 54% are single; 44%, married, and 2%, widowed or divorced. Regarding their level of education, 0.7% are illiterate; 0.3% have minimal literacy; 46%, incomplete or complete elementary school; 44%, incomplete or complete secondary education and 9%, incomplete or complete higher education. Among the beneficiaries, 67% did not have formal employment Of the total pregnant women cared for, 74% began PIM care prior to 22 weeks of pregnancy (SisPIM, 2016).

When analyzing the total number of visits performed in 2016, 27% of the pregnant women were found to be adolescents, 48% were between the ages of 20 and 30, and 25% were over 30 years old. The majority (30%) are between 20 to 25 years old (SisPIM, 2016).

Figure 8 - Age of pregnant women receiving care



Source: SisPIM - December 2016

Beneficiary children

Of the children that received care in 2016, 51% are female and 49% are male. Regarding race/color, those responsible for children stated that 82% of their children are white; 16% are brown or black; 2%, indigenous or yellow, and the others did not report. Regarding the degree of education of the mothers, 1% are illiterate; 0.5% have minimal literacy; 49%, incomplete or complete elementary school; 40%, incomplete or complete secondary education; 7%, incomplete or complete higher education, and the others did not report. Among the fathers, 8.7% are illiterate; 0.5% have minimal literacy; 51%, incomplete or complete elementary school; 34%, incomplete or complete secondary education; 3%, incomplete or complete higher education, and the others did not report (SisPIM, 2016).

Rio Grande do Sul has a rate of 3.2% of the total population that declared themselves as Person with Disabilities - PCD (IBGE, 2010). The percentage of the population is not specified for children in the early childhood period. According to SisPIM (2016), there is a record of 2% of children with disabilities upon entry into

PIM. To record this information within the child's initial register, a medical report is necessary. PIM experience has revealed that the number of children with disabilities cared for has increased during the Program's involvement with the family, since the Visitor and the team play an important role in identifying signs and/or symptoms not previously perceived. Also, some disabilities take time to be diagnosed.

The care given to children with disabilities is in line with the *Primeira Infância Melhor* methodology through unique care plans that seek early stimulation and strengthening of bonds. In addition, once again intersectorality becomes present and necessary. PIM monitoring is carried out with the support of professionals from the service network who help in determining what types of activities contribute to the integral development of these children.

CHAPTER 3

MONITORING TO ENSURE PIM QUALITY

Primeira Infância Melhor has a monitoring system organized into four action levels: monitoring of the pregnant woman or the child; monitoring the Visitor's actions; monitoring the municipal teams and Program assessments. These processes receive important support from the PIM Information System - SisPIM, which contains data from 44 thousand pregnant women, 195 thousand children, 166 thousand families, and 10 thousand Visitors who went through the program over the years (SisPIM), 2016). Also, exclusive practices and instruments have been developed by the state technical team and will be explained in detail below.

PIM Information System (SisPIM)

Developed especially for the Program, the PIM Information System - SisPIM is configured as the main monitoring tool. It must provide data related to children cared for, families, mothers/pregnant women, professionals, Visitors, and territories involved in the program. It provides support for the preparation of analyzes, planning and decision making by managers and PIM members.

The information recorded online in the system is collected by completing the initial characterization forms for the beneficiaries, monitoring the development of pregnant women and children, as well as other administrative and functional forms. SisPIM also includes the support material sent to the municipalities, such as the orientation guide, material instruments for training, etc.

SisPIM is made up of three sections: record, reports and, instructions bank. In the records section it is possible to record and consult information such as: sociodemographic data; data from the communities, families, pregnant women and children cared for; and data regarding child development monitoring. In the children's records, for example, it is possible to check questions related to gender, race/color, main caregiver, age of entry into the program, current age, address, Visitor in charge, National Health Card number - CNS, and Social Identification Number - NIS. In the report section, data and statistics are provided for consultation, such as: total care instances; care population profile; status of municipalities; funds paid by the State, etc. These reports are an important source for Program management by PIM teams and managers. In the instructions bank section, work tools are available.

It is the user's liability to keep the quality and protection of the information registered in SisPIM. Access is restricted and carried out by identification of user name and personal password. This mechanism helps out the security of information traffic and allows users to be identified by the information recorded or changed in the system. There are different levels of SisPIM access. GTE has access to information from all municipalities, however, it cannot include or modify information in the beneficiaries' records. GTM, Monitors, and Data Entry Professionals can only access the data of their municipality, and they can include, change, deactivate or exclude data. The Visitor can only visualize the municipality's data. In addition, state and municipal managers have access to view the registered data, so that they assist management actions. Currently, SisPIM has 2,234 active registered users. In the first half of 2017, the system recorded 406,963 accesses (SisPIM, 2016).

The reliability of SisPIM is directly related to correct filling out of forms, proper insertion of information into the system, and the mastery of its tools. SisPIM still presents incomplete data due to delays in data entry. To overcome this gap, the state team requires technicians specifically for the development and analysis of the system, for the formation of municipal teams and for permanent technical support for the users, either in person or by telephone and e-mail. The State also provides municipalities with computers, minimizing possible difficulties with equipment acquisition.

Facilitating access to information is one of the state team's priorities. In this sense, in addition to the activities described, GTE counts on professionals contracted specifically to elaborate evaluations of the system, pointing to qualification strategies that are gradually incorporated. Some examples of this strategy include: the information inclusion in the records that favor articulation with other information systems (for example: Social Identification Number); the improvement of data availability; the adoption of mechanisms that favor the autonomy of the user; the creation of filters that allow the analysis of different indicators (race/color, age, care periods), and the presentation of indicators in a way that facilitates and

accelerates the interpretation of the data; among others. Currently, the inclusion of new data is being studied, such as counting the number of visits made to each family per period; the adaptation of the system to enable access for people with disabilities, and updating the SisPIM user manual, an instrument that contains guidelines for its proper use.

In order to know the limitations and potential of the system, in 2014 GTE requested the completion of a questionnaire answered by 155 municipalities, representing 58% of those certified. The answers revealed that 72% of users considered SisPIM to be easy to fill out, and 28% reported having difficulties filling out the data. Of the difficulties pointed out, 41% were related to the lack of a specific professional to enter the data, followed by lack of training (36%) and slow internet connection (32%). The most important people in charge of data entry are the Monitors (34.9%), followed by the Data Entry Professionals (29.6%) and the GTM members (28%)[23].

This questionnaire has brought up important elements for discussion, such as the need for more training for users, which may mean that the system still needs to become more intuitive and accessible. It also aroused the interest in allowing the Visitor to register information in the system, with the proper supervision of their team, in order to make the information update in SisPIM more agile.

Monitoring of pregnant women and children

The monitoring of the pregnant woman and the child seeks to follow the development of these beneficiaries, optimizing the intervention actions and strengthening the integral development of children. It is an ongoing process, weekly conducted through home visits and group activities. Each meeting is an opportunity to follow how the family is developing their learning and care practices towards the gestation period and/or the development of their children.

The Quarterly Descriptive Opinion of the Pregnant Woman is the instrument that assists the monitoring of gestation, considering data from the gestational period, prenatal consultations, and possible risk factors. Also, it describes potential, fragility, and/or complications noted during the gestation, considering physical, emotional, social and community aspects; dynamics and family involvement in gestation; and possible referrals to the service network and/ or their outcome.

The **Monitoring of Integral Child Development** is carried out through three instruments. Initially, the Initial Diagnosis of Child Development (Baseline)[24] is carried out, it is characterized as the baseline of child development. This instrument, in which the evaluation of the development indicators is recorded, is applied by the Visitors before the beginning of the Care Modalities. This evaluation is carried out in accordance with the indicators by age group established by PIM methodology: 0 to 3 months; 3 to 6 months; 6 to 9 months; 9 to 12 months; 12 to 18 months; 18 to 24 months; 2 to 3 years; 3 to 4 years; 4 to 5 years and 5 to 6 years. For each age group there are, on average, eight development indicators to be observed. The evaluation carried out by the Visitor defines whether the child can already carry out such a development indicator on their own, with assistance, or is unable.

For example, by the end of the third month

23 Data extracted from the internal research entitled "Monitoring of SisPIM", done in 2014 with 155 municipalities in Rio Grande do Sul. Non-published document.

24 Instrument based on the Development Monitoring Form adapted from the version elaborated by Brant, J.A.c.; Jerusaliski, A. N. and Zannon, C. M. I. C.. by the Ministry of Health (2002); Table of Child Development Gains (Celep/Cuba); Denver Scale II Technical Manual Frankenburg, WK; Do.

of age, there have been evaluated the development indicators that include the following behavior and abilities: "smiles when facing a person's face", "recognizes and reacts to the voice of the mother/caregiver", "makes sounds as a form of communication", and others. At the end of the sixth month, other behaviors and skills are monitored, such as: "Recognizes people who they are close to and cries before strangers," "sits with help or alone for a while," "looks for objects in front of them." The list of all development indicators monitored by PIM is available on the Program's website (www.pim.saude.rs.gov.br).

Then, the **Quarterly Descriptive Monitoring** begins, it is the point when the Visitor registers the advances and difficulties related to the integral development of the child, observing four dimensions: socio-emotional, motor, language/communication, and cognitive. These records are done based on the Visitor's observations at the moments of care in the Individual and Group Care Modalities.

Finally, the **Evaluation of Child Development** is carried out, it points out the expected behaviors/competencies for each of the age groups provided in the methodology of the Program through the playful activities. This instrument has the same configuration as the Baseline. For each age group there are, on average, eight behaviors to be observed.

Besides that, one should register: the child's health details, the family involvement/ dynamics within the social and the community aspects, as well as the potential referrals to the service network and /or their results.

The **Quarterly Descriptive Monitoring** and **Evaluation of Child Development** point out the potential of children and what development dimensions need to be strengthened. This monitoring serves as a reference for analysis, comparison, and monitoring of the child's gains during the phases of their development.

All the information regarding the monitoring of the pregnant woman and the child is documented, discussed with the team, and analyzed under supervision, recorded in SisPIM, and especially discussed with the families during the Care Modalities. Such monitoring does not intend to judge or label beneficiaries, on the contrary, it offers details that serve as a stimulus for reflection and greater knowledge about what is expected in terms of development, respecting the individuality of each subject. It also serves to benchmark the Visitor's effort and the results of the Program in strengthening families.

Another way to monitor the development of the child is the **Monitoring of PIM Former Participants**, which takes place in a partnership between the GTM, the Regional Education Office, and the management and faculty teams at municipal schools. This evaluation is carried out during the first year PIM former participating children are enrolled in school. The student's teacher prepares a descriptive opinion in August and December, abiding by the following guidelines: "Under the focus of the social-emotional, cognitive, motor and language/ communication dimensions, your opinion is requested regarding the development of the PIM participant with respect to autonomy, interaction and cooperation, potential, and abilities, as well as the family's participation in school life" (Bernardes, 2010).

Monitoring the Visitor's actions

The complexity of the Visitor's work requires permanent support from the municipal teams. For this purpose, a series of monitoring processes and instruments have been developed. The monitoring of the Visitor is done by the Monitor and GTM, and is carried out in weekly meetings, supervision of the care cases, discussion of the **Care Modality**

Plans, and monitoring visits. The monitoring visits carried out by the Monitor and/or GTM seek to broaden the guidelines to the family, support the Visitor in more complex situations, identify family satisfaction with the Program, and evaluate the Visitor's performance.

The **Home Visit Observation Script** is another instrument used to monitor and evaluate the quality of the visit and serves as a basis for feedback and guidance to the Visitor's plans, as well as for conducting continuous supervision and training. There is also the **Monthly List of Pregnant Women and Children Cared For** which records the number of Care Modalities and other meetings with the families planned and executed during the month by the Visitor. This document gives rise to the **Monthly Memo** and the list of activities that should be delivered to the Municipal Technical Group.

The results of the monitoring process are especially addressed on weekly supervision, in which are discussed the weaknesses, attitudes, knowledge, and practices of the Visitor, with the focus on their qualification to better respond to Program objectives. When the Visitor does not respond to the guidelines, he may suffer sanctions, and may even be removed from duty. This is an individual decision of each municipal team and must be supported by the municipality's legal department.

Monitoring municipal teams

The State Technical Group counts on professionals who act primarily in the monitoring of the municipal teams. These professionals are arranged in a georeferenced manner and monitor approximately thirty municipalities, which allows the attention given to the peculiarities of each territory. The monitoring of the municipal teams aims to support them in the issues related to the management and methodology of *Primeira Infância Melhor*, co-constructing ways to guarantee its quality in each territory. This monitoring is carried out through quarterly visits to municipalities, in addition to constant monitoring at a distance, through different strategies.

For the periodic visit, the **Advisory Script** is used, which provides different points for the meeting: initial meeting only with GTM for general contextualization of PIM; meeting with GTM, Monitors and Visitors for listening, discussion, and clarification of the topics addressed; prior presentation of the Care Modality Plan to be executed that day; monitoring the Care Modality; meeting with GTM, Monitors, and Visitors to get observations feedback, continuing education and referrals; meeting with municipal managers in order to discuss the Program impact, the methodology alignment, and the investment strengthening in actions directed to early childhood.

When necessary, the GTE representative can use the Home Visit Observation Script to assess the quality of the Care Modality and may have one more documentation instrument to provide tools for the municipal staff. Finally, the **Visitor Record** is completed, which makes official the on-site monitoring, contemplating aspects discussed regarding the current PIM situation in the municipality, agreed referrals, and respective deadlines, in addition to other observations that may impact the Program. This document is signed by the managers and GTM and GTE representatives.

Remote monitoring is constant and adopts different strategies: telephone contacts, e-mails, Internet meetings, analysis of the **Quarterly Report**, reports, analysis of the information contained in SisPIM, etc. To assist in such monitoring, the municipal teams fill out the **Monitoring Script of PIM Action in the Municipality**, which is an exercise in analysis and reflection of the structure and general operation of the Program, it is to GTE for the improvement of actions and teams.

Evaluations conducted

The importance of evaluating a public policy such as PIM has three main arguments. First, it allows policymakers to analyze whether investments are profitable and decide the best way to allocate resources. Secondly, it is an opportunity to know the intervention points that need to be improved, as well as strategies to promote it. That way, evaluation is a feedback process to achieve greater impact on the population (Berlinsky & Schady, 2015). Finally, it generates evidence to inspire and reformulate policies, since it allows us to know what works and what does not work under certain contexts, which is particularly relevant for PIM, because it is Brazil's oldest program in terms of early childhood care and monitoring. From the organization of the technical structure to the creation of SisPIM, the *Primeira Infância Melhor* Program recognizes that monitoring and data collection are essential to guarantee the quality of the Program. However, the efforts made so far have not been sufficient to clearly and convincingly assess (in terms of statistics and arguments) the impacts of PIM on the target population. Next, we describe the studies that have tried to partially evaluate the Program.

Evaluation of the Primeira Infância Melhor Program
Latin American Reference Center for Preschool Education

In 2010, there was a monitoring evaluation of the PIM implantation and implementation processes in the state. Under the coordination of the Latin American Reference Center for Pre-School Education/Cuba, the research sought to evaluate the results of the integral development of children accompanied by the Program in comparison to the children of the control group (including children without care in any program or early childhood education institution). In addition, PIM management related were evaluated, such as the participation of managers, the performance of the municipal team, and the perception of beneficiary families. The survey included 1,359 participants from 16 municipalities.

The survey suggested positive results for PIM regarding the development of the beneficiary children in comparison to the children of the control group. The gains achieved by the beneficiary children were higher than those of the control children by 16 percentage points in the socioemotional dimension, 23 in the motor dimension, 8 in the cognitive dimension, and 10 in the language dimension. According to family perception: 97% believed that their participation in PIM changed the way they treat their children and 53% of the families began to observe that their children were more communicative. In relation to the activities suggested by the Visitors, 51% of the families stated that they did them daily and 34% did so several times a week (CELEP, 2010).

This study has weaknesses regarding research design, sample selection, and statistical analysis. The results obtained do not count as a parameter to demonstrate the impact of *Primeira Infância Melhor* on the development of children receiving care. However, the evaluation was relevant in the process of qualifying PIM, since it was possible to analyze the implementation stages of the Program along with Celep and to re-adjust potential flaws.

Evaluation of the Primeira Infância Melhor Program in relation to school readiness for children between four and six years old in Rio Grande do Sul

Janus & Duku, 2012

In 2011, the Early Development Instrument (EDI[25]) was applied to 670 children (433 of the treatment group and 237 of the control group) between four and six years of age, attending the first school year (level A or B of elementary education) and belonging to 8 representative municipalities in Rio Grande do Sul (in terms of socioeconomic features).

In addition to the above requirements, in order to belong to the treatment group, the children had to have been PIM beneficiaries for at least six months, have not participated in other child intervention programs, and have an updated address, while the children in the control group should be in the same classrooms as those in the treatment group and belong to families selected by the classroom teachers (Janus & Duku, 2012).

As a result of the study, it was reported that the percentage of vulnerable children, those with scores below the cutoff point suggested by the creators of the instrument (the cutoff point is equivalent to the score obtained by children in the 10th percentile of a Canadian reference sample), are between 8.1% and 14.5% for all domains, except for the language and general knowledge, which the percentage is 37.9% for children of the treatment group and 42% for those in the control group. This indicates that, regardless the group assignment, the children in the study developed according to their age expectations similarly to children in the Canadian sample in all domains except for language and general knowledge.

On the other hand, by analyzing the arithmetic means (without reporting levels of statistical significance), the authors discovered that the children who participated in PIM had slightly higher scores than the children in the control group. However, these differences disappear or are reversed (the children in the control group obtain better results), when analyzed through variables such as maternal education level, income, home exposure time and the school attended by the child (Janus & Duku, 2012).

These results cannot be interpreted as a real effect of PIM because the research methodology presents different weaknesses, including the selection of a sample that was not random, which implies that there is a selection bias for observed and unobserved variables. Thus, the children in the treatment groups have different characteristics than children in the control group, which makes them a less than ideal comparison group (counterfactual) and that the effects found do not correspond to the real impact on the program. On the other hand, the analysis methodology is not recommended, and lacks relevance and statistical power.

25 EDI is an instrument developed at McMaster University, which aims to measure whether children develop according to their age expectations in five domains: physical well-being; social competence; emotional maturity; language and cognitive and communication development; and general knowledge. The instrument consists of a questionnaire of 103 items or questions that must be filled out by pre-school teachers. It must be stated that the study offers evidence for EDI validation in Brazil : https://edi. offordcentre.com/about/what-is-the-edi/

Evaluation for improved cost effectiveness, qualification and expansion of the Primeira Infância Melhor Program
Fundação Getúlio Vargas, 2014

In 2014, a consulting project by Getúlio Vargas/RJ Foundation was done to discuss the "Evaluation for Improving the Cost-Effectiveness, Qualification, and Expansion of the *Primeira Infância Melhor* Program". Despite this nomenclature, the project carried out by the institution focused more on the knowledge of the Program and its work processes. The results presented regarding the evaluation of results concern only one aspect of the study: the assessment of the caregivers' perception. This aspect includes results regarding the degree of importance of the PIM for families, the perception about the quality of the services provided, as well as the main positive aspects of the Program.

The research was carried out by a questionnaire with 1,600 respondents, selected by stratification according to the macroregions of the state, number of PIM beneficiaries per municipality, and age group of the PIM beneficiaries (0 to 3 years old and over 3 years to 6 years old) , representing a sample of 8% of the total families assisted in the state. The questionnaire was elaborated based on the results of in-depth interviews and focus groups conducted in the phases prior to the survey, and validated by GTE, considering the following analyses blocks: evaluation of the service provided by the Program; family and Visitor relationship; and perception of PIM impact (Fundação Getúlio Vargas, 2014).

As a general result there is great acceptance and satisfaction with PIM. Regarding the evaluation of the service provided by the Program, 96% of the caregivers considered PIM to be important or very important and 93% considered the quality of the service provided to be optimal or good. Of the respondents, 87% answered that PIM impacted their preparation for providing child care and 95% of the caregivers said that they consider the activities oriented by PIM would contribute to improving the child's living conditions in the future. Regarding the relation between family and Visitor, more than 80% of respondents showed a high degree of confidence in the Program, including 32% who consider the Visitor as reliable one or someone they can talk to. Although, only 60% had the same Visitor during their participation in PIM.

Although there is no consensus about the quality standards of a home visit, the literature points out that the interrelationship between the frequency, content, and relationships between users, caregivers and children constitute quality (López-Boo *et al.*, 2016; Paulsell *et al.*, 2010). However, the relationship between these dimensions is not linear; therefore, more visits or a closer relationship between the families and the visitors doesn't always mean better results (Stolfuz & Lynch, 2005). It is so that both the change in the Visitors during PIM, as well as a close relationship with the Visitor, deserve to be examined carefully, since they can affect the quality of the visits.

A Snapshot on the Quality of Seven Home Visit Parenting Programs in Latin America and the Caribbean
Leer et al., 2016

In a broader context, Leer *et al.* (2016) inquire about the interactions between the Visitor, parents, and children; the content of the activities and the intervention strategies that occur during visits performed through seven home visiting programs (five programs focused on child care, stimulation, and development, and two focused on verifying nutritional

indicators) in different Latin American and Caribbean countries, including *Primeira Infância Melhor*. A checklist developed by the University of the West Indies was used as a measurement tool and consisted of 31 items and 7 sections that allow an approach to the quality of the visits.

Through the observation of five home visits in the municipality of Ronda Alta, PIM Visitors were shown to have a great understanding of the characteristics and needs of the families and were able to adapt the activities to the interests of the children, and also prepared the visit content with enough time. However, the Visitor spends more time focusing on the child and could work more to promote caregiver participation. Although the programs studied are not directly comparable because they differ in size, content, and reach, PIM scored the highest on most indicators.

In addition to the limitation about not allowing comparisons between programs, the sample size is small and therefore not representative of the quality of each of the programs; the visits were scheduled previously, so there was no completely "natural" environment; the checklist did not have a validated relationship to child development indicators and, for the specific case of Brazil, the selected families did not correspond to the most vulnerable population.

Primary Care in Family-Based Health: An Empirical Evaluation of the Primeira Infância Melhor Program in Rio Grande do Sul - Brazil

Garcia et al., 2017, ongoing

It is important to mention that, although this study is still in progress, it is identified as the most rigorous statistical evaluation and the first to use administrative data provided by the Health Department of Rio Grande do Sul and the Brazilian Ministry of Health.

Using the differences in admission and time of exposure to the PIM in 496 municipalities of Rio Grande do Sul during the period between 2006 and 2010, Garcia et al. (2017) investigated the effect of PIM on mortality caused by diarrhea, general causes and external causes (deaths that are caused by accidents that could be avoided if the caregiver offered more attention) in children under one year old. In this analysis the difference-in-differences approach is used and it revealed that in municipalities that had exposure equal or superior to seven years, PIM reduced the external causes of deaths per 1,000 children by 0.68 (significant to 5%), while the exposure in municipalities that lasted between four and six years, the effect is 0.45 (significant to 10%). In municipalities with fewer years of PIM exposure (0 to 3 years), the effect on deaths caused by diarrhea per thousand children was -0.10 (significant to 10%).

As the authors mentioned, the research has several limitations, including the selection of municipalities, which was not random, which implies that the municipalities that implemented PIM may have systematically different characteristics, a fact that affects the indicators being studied. The differences-in-differences methodology is based on the assumption of parallel trends, that is, that the behavior of the growth rate of the variable of interest (infant mortality rates, in this case) follows the same trend in the absence of treatment (PIM). However, no evidence is given in this regard. The absence of parallel trends may be leading to results such as those observed. The results over the relationship between effect and intervention are so high that, on average, they lead to negative mortality rates. In the extreme case, this would imply that PIM is bringing the mortality rate caused by diarrhea or external causes to zero, which is questionable, since the municipalities with

PIM currently implanted, four years after the analysis period, still have positive mortality rates associated to the causes in question.

Finally, the aggregation of indicators at the municipal level does not capture the real effect of the Program. On the one hand, PIM only benefits a portion of the population of the municipalities; and, on the other hand, they may have synergies with other interventions, such as the Family Health Strategy, despite controlling for variables such as health services, health workers, and immunization coverage.

Cost-effectiveness analysis

The evaluation of a public policy will provide information regarding the outcome of the investments and the best way to allocate resources only if it is accompanied by a cost-benefit analysis or a cost-effectiveness analysis, comparing costs with results or effects generated. Unfortunately, PIM does not have sound assessments that determine the true effects on social welfare, which, therefore, hinders the development of a reliable cost-effectiveness analysis of the Program. However, as an illustrative exercise, a cost-effectiveness analysis of the impacts generated by PIM is presented below, based on the calculation of the monetary costs of the Program by Disability Adjusted Life Year[26] (DALY) avoided.

According to the PIM[27] cost analysis in 2016, the per capita annual program cost is USD 286.8 (USD 142.32 for costs associated to the state level and USD 144.48 at the municipal level). So, by applying a discount rate of 3%, it is estimated that PIM cost USD 15,747,757.67 in 2012 (per capita cost discounted by the total number of beneficiaries).

The results of Garcia et al. (2017) report that PIM reduces annual deaths from external causes by 0.68 and 0.45 per 1,000 children, depending on the municipality's time of exposure to PIM. In addition, the effect on deaths per 1,000 children caused by diarrhea is -0.10 for municipalities with less PIM exposure. In an extreme case, this would imply that PIM is bringing mortality rates caused by diarrhea or external causes to practically zero. Multiplying these rates by the number of children under one year old in Rio Grande do Sul in 2012, it is estimated that PIM would have prevented the death of 547 children, equivalent to 46,866.96 DALYs avoided (multiplying the number of deaths would be avoided by the life expectancy of 85.68 years in 2010, defined by the World Health Organization -WHO)[28]. Thus, the cost per DALY avoided would have been USD 336.1.

By comparing the cost per DALY avoided (USD 336.1) with three times the country's GDP per capita (USD 36,471.92), according to the general rule established by WHO, which states that the first amount should be less than the second, PIM would be considered highly profitable. However, this type of decision rule, where specific limits are set on which to compare, has several limitations. According to Marseille *et al.* (2015), such limitations may be: they do not allow comparisons to other policies that are also classified as cost-effective; the threshold is easily achievable and arbitrary (e.g. in the case of the PIM, if compared to less than one GDP per capita the intervention is still profitable); they assume that GDP per capita is

26 Considering the difficulty of measuring the effects of policies in monetary terms, especially those related to the health sector, as well as the need to generate a comparative and consistent description of the diseases, the World Health Organization developed the Disability Life Year (DALY). The DALYs, or the burden of a disease, are calculated as the sum of years lost due to deaths plus the years of healthy life lost due to disability caused by illness. So a DALY can be interpreted as a year of healthy life lost (WHO, 2017).

27 Calculation presented in the document "Custo per capita anual do PIM no estado e municípios". Internal unpublished document.

28 Only the years of life avoided due to premature death are considered, since the effects are only observed for mortality rates. In any case, this would imply that the estimates presented correspond to a lower limit. In addition, WHO does not have DALY estimates due to external causes. For a discussion about why it is not discounted nor is it age-weighted, see WHO (2017).

the provision to pay socially for a healthy year of life, which is not a consolidated fact and can vary between low and high income countries; and finally, it ignores the budgetary constraints of governments.

Final remarks

The studies described represent an interest in evaluating PIM and indicate that PIM has generated positive effects on families and children. However, they have significant limitations in terms of representativeness and to establish a control group that can actually be compared to PIM beneficiaries and thus obtain a better approximation to the real effects of the Program. There are very few studies that evaluated PIM from the effects generated directly upon the promotion of child development, the primary objective of the Program. The authors agree with the importance of generating longitudinal or experimental information that allows the evaluation of children, not only on the physical dimension, but also their cognitive and psychosocial development; and to estimate the cost-effectiveness of the intervention.

CHAPTER 4

INNOVATING EARLY CHILDHOOD CARE

The PIM trajectory led to its recognition as one of the most important development and social transformation technologies in Latin America: Beyond the quantitative results of the presented evaluations, there are stories of life and reports from families in their daily routine that prove the Program's quality and the power that this policy has to promote life, to transform stories, to empower families, and to potentially break the cycles of vulnerability. As PIM became structured and was strengthened, not only its results have reflected upon beneficiary families but also on society as a whole. The impact of *Primeira Infância Melhor* is evident in extending the culture of investment in early childhood in Brazil and Latin America.

Widening the culture of investing in early childhood

In addition to direct work with families, PIM seeks to influence governments and society in the formulation, approval, and execution of initiatives that meet the needs of early childhood, strengthening the participation of different actors in the debates of interest to this cause. In order to keep the topic of early childhood care in the forefront, as well as to ensure the sustainability of the Program, advocacy has become a key strategy. State Baby Week, Baby Day, International Early Childhood Seminar, Salvador Celia Award, Radio Broadcaster Training, municipal events, meetings with managers, social control, publicity campaigns, information material for the media, and others are part of the *Primeira Infância Melhor* advocacy actions.

State Baby Week/PIM takes place annually in November, and includes Baby Day, the International Early Childhood Seminar, the Salvador Celia Award, and other promotional activities for early childhood both in the State and municipalities. This was inspired by Baby Week in the city of Canela/RS and also inspires different states in Brazil and other countries. Due to its importance, State Decree no. 42.200/03 instituted an official calendar for State events.

Baby Day seeks to mobilize society regarding the importance of care during the early stages of life. The activities on this date take place in the main park of the state capital (state level) and in community areas (municipal level), providing pregnant women and children, along with their families, with playful, artistic, and cultural activities as well as information and services in the area child development, health, social protection, culture, and education.

The International Early Childhood Seminar[29] aims to foster the exchange of knowledge and experience among experts, researchers, educators, managers, PIM teams, and civil society regarding current issues that are relevant to early childhood causes and the home visit efforts with families in situations of risk or social vulnerability. The seminar usually takes place over two days, bringing together around 2,000 people.

The Salvador Celia Award seeks to promote the integration of Primary Care Policies and to publicly recognize the good practices of PIM Visitors and ESF Community Health Workers, both professionals responsible for home visitation in the territories. It also represents an incentive for teams to recognize the value of their work and to broaden their articulation proposals, just as it is an important action to mobilize municipal management for involvement in the cause and to value the work carried out by its teams.

Another important way that PIM has used to expand the culture of investment in early childhood is its insertion in the media. That way, it places the theme of children's rights, early childhood and child development on the public agenda. This makes it possible to mobilize a different audience from those participants that are formally part of their list of partners, which enables the use of the most diverse tools to disseminate their actions and speeches.

An important action in this regard is training for radio broadcasters, based on the Unicef primer. This training empowers broadcasters to include the theme of early childhood in their programs. Radio is an important means families use to access information in the communities where PIM gives assistance, and many municipalities have disseminated this practice by strengthening the culture of having a space dedicated to PIM in the local radio programming. Generally, the Program and issues related to child development, health, access to rights, culture, and education are discussed.

29 Appendix 2 lists the events held, with topics and speakers.

PIM also is present in digital media. Its website (www.pim.saude.rs.gov.br) aims to disseminate *Primeira Infância Melhor* projects, actions, activities, and services; to provide state information online; to contribute to the creation, consolidation and strengthening of public policies directed toward early childhood; etc. The Program also has a Facebook page, and an account on Twitter, Instagram, and YouTube, as well as a newsletter mailing.

In addition, *Primeira Infância Melhor* promotes and/or is referenced in newspapers, magazines and websites, national and international documentaries, television reports, and other medias, influencing public opinion about the early years of life and engaging relevant actors in this discussion.

Inspiring and supporting the implantation of other national programs

The practice of *Primeira Infância Melhor* has made it benchmark for early childhood projects and home visits. The Program frequently receives government representatives, institutions, and professionals from the most diverse areas that want to know its structure and functioning. Likewise, representatives of the State Technical Group travel to different countries, states, and Brazilian municipalities in order to disseminate the experience of the Program.

In Brazil, through institutional partnerships, PIM inspires and supports the implantation and implementation of different actions/projects/programs for early childhood both technically and methodologically. It should be noted that the support of the Program occurs in different levels: in the structuring of the management teams; in the construction and adaptation of instruments; in the preparation of the curricula of the home visits, and the training methodology of the teams involved; among others. Table 6 illustrates the basic conformation of the PIM supported initiatives, presenting their objectives, target audience, and operating structures. They represent the effort of an interfederative collaboration that resulted in mutual learning, also qualifying the effort developed by PIM.

In total, nine initiatives are supported by PIM in the South, Southeast, Northeast, and North regions, places with different geographic, social, cultural, political, and economic configurations. The exercise of replicating PIM for such diverse territories requires a careful reading of these contexts in order to produce models of attention compatible with them. Sometimes, significant changes are required in the original PIM model, however, some aspects have always been maintained, such as: the intersectoriality as principle for care organization; the structuring of management teams composed of members of Health, Education, and Social Assistance; the appreciation of the experiences and culture of the families and the communities; the objective of promoting the strengthening of family skills and their active participation, and investment in the qualification of the teams around the territories. It is important to emphasize that in all experiences, the active participation of local teams in the entire process of replicability is fundamental, as well as support from managers, academic and research institutions, and financing bodies.

Table 6 - Actions/projects/programs inspired by PIM

Program	Objective	Curriculum
Atenção à Primeira Infância e à Maternidade. Munhoz de Melo/PR	To capture the pregnant woman early on, ensuring quality prenatal care and the integral development of the child.	Yes, based on PIM.
Atenção Melhor à Infância Vila Velha/ES	To orient families and work with family and community coexistence, increasing interaction between parents and children, seeking to strengthen their competencies to educate and care for children.	Yes, based on PIM.
Primeira Infância Ribeirinha Iraduba, Novo Airão e Manacapuru/AM	To work with developing pregnant women and children from 0 to 6 years old in river bank communities.	Yes, based on PIM and other sources.
Programa Cresça com Seu Filho Fortaleza/CE	To assist families in situations of social and economic vulnerability, based on their own culture and experiences in order to promote the integral development of children during gestation and early childhood (from 0 to 3 years old).	Yes, based on PIM and other sources.
São Paulo Carinhosa São Paulo/SP	To articulate, coordinate, share, and expand actions done in the city of São Paulo to promote integral development during early childhood.	No
Primeira Infância Acreana Acre	The Primeira Infância Acreana (PIA) Program was created to improve care and service for pregnant women and children aged from 0 to 6 in vulnerable situations, favoring their integral and integrated development.	Yes, based on PIM and other sources.
Agenda de Atenção Nutricional à Desnutrição Infantil	To encourage ANDI (High Rates of child malnutrition) municipalities to use a model of integral healthcare, with a focus on the qualification and articulation of services to struggle malnutrition and encourage development during early childhood.	No

Other initiatives also had the technical and methodological support of PIM. As of 2012, in response to an invitation from the Ministry of Health, technicians of the State PIM Team collaborated in the elaboration of the new Child Book; in the structuring of a distance course on early childhood development, and the elaboration and execution of a training methodology for managers and municipal health, education, and social development professionals on the theme of child development. PIM collaborated in

Method	Target-market	Visitors	Supervision
Home visit and group activities based on the PIM visit script.	Pregnant women and children from 0 to 3 years old.	Yes, exclusive for the Program.	Yes
Home visit and group activities based on the PIM visit script.	Pregnant women and children from 0 to 5 years old.	Yes, exclusive for the Program.	Yes
Home visit and group activities based on the PIM visit script.	Pregnant women and children from 0 to 6 years old.	Yes, Community Health Workers.	Yes
Home visit and group activities based on the PIM visit script.	Pregnant women and children from 0 to 3 years old.	Yes, Community Health Workers.	Yes
Construction of new school units; elaboration of a curriculum for early childhood education, elaboration of criteria for prioritization of access to early childhood education to children in situations of greater vulnerability and family welcoming Program.	Children from 0 to 6 years old.	No	No
Home visit and group activities based on the PIM visit script.	Pregnant women and children from 0 to 6 years old.	Yes, Community Health Workers.	Yes
Training of ESF teams. Home visit and group activities.	Children under 5 years old.	Yes, Community Health Workers.	No

Source: Official sites of actions/projects/programs

the construction of the axes that refer to the development in early childhood of the National Policy of Integral Care for Children's Health of the Ministry of Health in 2015. Lastly, a historic breakthrough for the promotion of the first years of life was the Legal Framework for Early Childhood (2016), which seeks to guarantee the rights in several sectors aimed at promoting integral development, using *Primeira Infância Melhor* as a reference model of home visitation.

Challenges and achievements throughout this trajectory

The fourteen-year trajectory of *Primeira Infância Melhor* enabled the learning of lessons related to overcoming the challenges inherent to innovative public policy in Brazil. These challenges include diverse aspects of the social, political, cultural, and economic reality of the State of Rio Grande do Sul and stimulate its constant improvement.

In Brazil, federal, state, and municipal governments change every four years. This can cause discontinuity in actions related to PIM according to the priorities of each administration term. However, the institutionalization of the Program in the State and in the municipalities through the creation of laws, and through the establishment of positions to fill the Program, providing goals and budgets for local plans are strategies that help maintain PIM and minimize the effects of administration changes. In addition to this, the articulation of the Program along with other administrative spheres, such as the legislative sector (City Council and Legislative Assembly) and Social Control (Health, Education, and Social Assistance Councils among others); the valorization of early childhood supported by scientific evidence, and the sense of belonging of the families towards PIM all favor the defense to sustain this public policy.

Not only does PIM intervention focus on children, but also on other members of the families, it respects the individuality of each individual and the family dynamics. This involves the Program's investment in valuing the historicity, culture, and habits of beneficiary families, also perceived in the development of specific efforts towards traditional (*quilombolas* and indigenous) and specific communities (incarcerated or formerly imprisoned mothers).

Besides the concern for the development of care practices that respect the ethnocultural peculiarities of these communities, PIM has as challenge the contribution to overcoming the vulnerabilities that these populations are more intensely exposed to. In the last decades, Brazil has shown improvement in indicators related to hunger, infant mortality, and access to basic sanitation, for instance. However, these populations did not keep up with these advances and have a hard time accessing social policies[30], especially those residing in areas that are difficult to access, which requires a major effort by PIM and strong articulation with other health, education, and social development policies; awareness of the managers and professionals of the service network and a constantly approaching community leaderships.

Likewise, it is important to highlight the value of paternal participation and/or male caregivers in the interventions and in the materials developed by the Program, strengthening men's responsibility in the care of their children, which is fundamental for the construction of children's emotional security and stability, often neglected by public policies for early childhood (Pereira, 2015).

PIM operations depend on a fundamental aspect for the execution of a public policy focused on the integrality of care: intersectoriality. This is a practice inaugurated by *Primeira Infância Melhor* in the municipalities of Rio Grande do Sul, once there hadn't been any culture of sharing public policy management among departments until its creation. The investment in integral care and the development of strategies that see the subject in his completeness requires breaking away from fragmented practices for managing and organizing services. Intersectoriality is encouraged in all aspects of PIM's political and administrative organization, whether they take place in the establishment of the municipal team, in sharing responsibilities, in agreeing on

30 According to a Food and Nutrition Security Assessment Survey in Quilombola Registered Communities (Angels, 2013), 41.1% of children and adolescents living in quilombola communities live with hunger or risk of starvation. The indigenous infant mortality rate increased from 31.90 to 43.46 deaths per thousand live births - twice as many as Brazil's average rate (15) and similar to countries like Namibia or Sao Tome and Principe (Bedinelli, 2015).

priorities, in discussing municipal committees and/or monitoring beneficiaries.

Among the conditions for satisfactory intersector operations, and the consequent success of PIM, there is a need for manager support of technicians performance, i.e., it is necessary that, besides the profile, GTM representatives may be excused to work in the Program and to take part in training processes. If not so, they are not in a position to offer the necessary support and monitor the quality of the PIM actions due to a lack of support. This challenge directly impacts the result of the actions (Zorzan, 2012).

One of the difficulties for municipalities to overcome is the lack of local legislation specifically for the Program, often representing an administrative obstacle to the hiring of Visitors, which depicts one of the greatest challenges of local management. In addition, once the Visitors are the professionals closest to the families, who are directly responsible for the quality of their relationship with the Program, it is essential that they also have an adequate profile for the performance of their activities and the management of interpersonal relationships. In general, it can be stated that the profile and performance of these professionals determines, to a large extent, PIM's credibility among the population.

The construction of knowledge and the appropriate practices for PIM context depends on the development of permanent training processes for all Program participants. The awareness of the municipal teams for the prioritization of training moments in their work routines, as well as the conceptual and practical alignment with the principles of the Program require the GTE representatives to constantly invest in the development of training methodologies and support materials that can assist in these processes.

It is worth emphasizing the importance of the PIM Information System for the proper functioning of the Program. This system is effective for a series of analyzes, research, and evaluations, since it has a wide range of information and many possibilities of use, which has been little explored so far. It is necessary to create new filters, facilitating the autonomy of users, and analysis of information already included in the system. In addition, it is necessary to make municipal teams aware of the constant maintenance of SisPIM by including all the provided care, as well as the detailed listing of the child development monitoring information, which allows the monitoring process to be qualified and the Program actions to be evaluated.

The reduction in the number of families each Visitor had to visit (from 25 to 20 families) was an important institutional achievement, fruit of the awareness-raising of managers and the political agreements. With this change, the Visitors started to have more time available in their weekly schedules for permanent education, planning, supervision, and evaluation of their activities, which enhenced the interventions and the results among the families. Likewise, the increase in early childhood education for children above four years of age extended the inclusion of families with pregnant women and children under four years of age, having achieved PIM's main focus.

Another important challenge for PIM, some of a technical and institutional nature, was the inclusion of care for children with disabilities. Initially, the practice of actions contemplated only the referral of identified demand to the network, which provided connections to specialized services. After intensive study of the state team, with the support of specialized institutions and responding to the demands of families, children with disabilities began to be included in PIM Care Modalities, with activities that were planned under the guidance of specialists.

Regarding research as a way of monitoring PIM results, in addition to those already carried out, there is also a need for a longitudinal or experimental study that analyzes the cost-effectiveness ratio and the impact of the Program interventions on children's development, families, and communities. This type of evaluation responds to the guidelines of a modern and efficient public administration, and contributes to the promotion of a

development agenda that is geared toward the public interest.

In view of all these considerations, the Primeira Infância Melhor policy is a great example of technology, innovation, and social development, due to the size of its structure. The implementation of the actions and the achievement of solid results come from managers committed to early childhood - and consequently a better society - as well as a great team that does not measure efforts, because their technical knowledge supports permanent investments in favor of an ideal that continues with legitimacy. In general, the policy is constantly strengthened by the authenticity of its existence.

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Appendix

1. Traditional and specific communities[31]

In all actions of the *Primeira Infância Melhor* Program, the culture and experience of each community is valued. However, there are specificities that need to be considered in adapting PIM methodology, especially in traditional communities: indigenous and *quilombolas*; and specific: riverside, countryside, forest, and water and incarcerated mothers. In order to respond to this demand, in addition to the instruments described in the PIM implantation and implementation section, the Cultural Mapping tool was developed to identify assistance tools for the adaptation and elaboration of the interventions and the playful activities to be implemented through the methodology of the Program.

The Cultural Mapping must take place after the Visitor Initial Training, also involving Monitors, the Municipal Technical Group, and PIM representatives in the Regional Health and Education Offices. In addition, there are community visits, interviews, and conversations with families in each community. This study begins with the PIM implementation process, but must permeate all the implementation actions, seeking to adapt the methodology to the local context. Nevertheless, each traditional or specific community has different characteristics, so there is no prompt script for the adaptations that need to be done. Therefore, three previous PIM experiences are presented below, which illustrate how the PIM implementation trajectory in these communities was presented.

Quilombola community[32]

In 2006, PIM implementation in quilombola area counted on the participation of members of the coordination and PIM technicians, of the Council for Development and Participation of the Black Community in RS and of the State Departments of Health, Social Assistance, and Education. Researchers, employees, and representatives of civil society interested in the topic also participated. This joint effort was fundamental to add knowledge and practices to an unprecedented proposal within the methodology of the Program. At the time, it was possible to discuss the epidemiological data of the population, and their struggles to access and guarantee constitutional rights, as well as the historical social and economic inequality they have undergone.

The proposal began with the mapping of the *quilombola* communities in the RS in order to identify the municipalities that already had PIM and which should raise awareness to implement the Program. In the opportunity, it was possible to verify the fragility of the data, because there was no neatness regarding the number of families and children residing in these communities.

In 2008, the PIM care proposal was initiated in the communities of Pedras Grandes and

31 Texts based on the reports of GTE representatives that monitored the PIM implantation process in these areas.

32 According to the 2010 Census, the *quilombola* population in Rio Grande do Sul is 10,248, of which 579 are in the age range of 0 to 4 years old.

Rincão dos Alves in the municipality of Bagé. There were several months of awareness raising and mobilization of managers and local technical teams regarding the importance of developing a specific work with these families. Among the challenges was the resistance of local leaders to adhere to the proposal, for the fear of interference that did not respect the culture of childcare and the organizational arrangements of communities. The support of the technical teams and municipal managers was fundamental to this process. The managers themselves made visits to the *quilombos* to talk to the leaders, helping strengthen the trust in the work that was going to be developed. The completion of the cultural mapping was an important strategy developed especially for this experience and that then was used in other initiatives to care for traditional and specific communities. The information gathered served as a basis for practices to revitalize the local culture and subsidized the organization of team formation methodologies, selection of contents to be worked on with families, and other implementation strategies.

The selection of the Visitors prioritized people from the community (a fact that is not a requirement in the other communities assisted) identified with the support of the leaders, which favored a closer relationship with families and local care practices. Visitors training was developed by GTM, with the support from GTE, and happened with a greater workload than the stipulated in the methodology, since it was necessary to include specific themes of the local culture. A distance of about 100 Km from the municipal headquarters was an important challenge to be overcome by GTM in the exercise of the Visitor monitoring activities - it was necessary to grant the support of managers for the provision of transportation and adequate workload for this purpose.

The developed activities prioritized articulation with health services, education, and social assistance, considering the need for integral care to the identified demands. The Program's care focused on the promotion and strengthening of family and community ties in the valuing ancestry, which is so important for the identity of Afro-Brazilian culture. Such activities arouse feelings in the care givers and family members that contributed to their self-esteem and self-image, with the valuing of their ethnic-cultural memory. The home visits were mainly aimed at strengthening the value of roots, through traditional games, cuisine, games, and folk songs, as well as storytelling. Encouragement to care for nature, as well as body experiences, allowed them to understand the meanings contained therein. In this way, they promoted their own identity as subjects of their history, and became aware of their potential to be and grow.

PIM sought to use this proposal to allow a different way of looking at the design of activities related to Afro-Brazilian culture, breaking away from sociocultural barriers and bringing visibility to these communities.

Indigenous community[33]

The first PIM experience in indigenous territory happened in 2010, in the municipalities of Iraí and Liberato Salzano.

In addition to the municipal managers (mayors and secretaries), indigenous leaders were consulted on their interest and how the process would take place in the indigenous area. After agreement of interests between the municipal managers and indigenous leaderships, a representative of the indigenous area (a native with a University degree) was added to the Municipal Technical Group. The PIM presuppositions were presented to the Chief and the councilors, including the explanation of Cultural Mapping.

33 In Rio Grande do Sul, according to the 2010 Census, the State has 10,693,929 inhabitants. Of these, 34,001 declared themselves indigenous, 18,616 of whom lived in indigenous territory and 2,145 were children between 0 and 4 years old.

The municipalities that implement the program in indigenous areas are instructed to select Visitors that belong to the community, that are indigenous, and that speak the mother tongue. These criteria are based on the maintenance and strengthening of the culture. The training provided to the Visitors is based on the logic of respecting the culture and experiences of this population, and it requires the presence of GTE professionals, the Special Department of Indigenous Health - SESAI, the Indigenous Special Sanitary Districts, in a dialogical relationship with the participants. When training is held in the village, in addition to candidates for the position of Visitor, all members of the community can participate: the Chief, councilors, Indigenous Health Agents - AIS, Indigenous Sanitation Agents - (AISAN), and residents, since the collective is part of indigineous culture and life. The training covers the themes of home visitation, early childhood development, and gestation, considering how ethnicity (in the RS the prevailing ethnic groups are Kaingang and Guarani) conceives children, their growth and development, gestation, community relations, etc, Once again, playfulness is a constant element of indigenous culture. Teaching is mostly done orally, through storytelling, music, and theater.

The Care Modalities occur in two ways: Individual and Group. The material used emphasize the value of the environment (seeds, baskets, wood). The Individual Modality is done at home, but it is not uncommon for several children to enter to observe and participate. That is part of their culture. The Group Modality, beyond the children and caregivers, is often accompanied by grandparents, cousins, relatives (as they say: everyone is a relative).

Transversalized by acculturation, non-indigenous and unhealthy habits affect the fragility of the culture, generate depression, alcoholism, and violence. A concerning fact is the infant mortality rate among indigenous children, which is even higher than among black children. PIM insertion in these areas is also permeated by the trend to help reduce infant mortality and to qualify other health indicators that do not match the improvements of the rest of the population.

Incarcerated community

Being aware of the importance of intervention in the first years of life, and knowing that in the context of prison mothers are the main or only family reference, *Primeira Infância Melhor* expanded its care to the prison community of the Madre Pelletier Women's Prison, located in Porto Alegre, capital of the state of Rio Grande do Sul. The purpose of this initiative is to stimulate and strengthen the mother/baby bond and to promote healthy integral child development through playful experiences, strengthening the leading role of mothers.

The pilot project started in 2012, which included study groups, raising awareness among the managers involved, conversations with the target public, articulation with the service network, and collection of the social and health data of incarcerated pregnant women and/or mothers. This project was elaborated and executed in partnership with the Department of Public Safety, through the Office of Penitentiary Services and through the Department of Criminal Treatment.

The Madre Pelletier Female Prison has a population of 224 inmates. Of these, 121 are mothers; 34% are between 35 and 45 years of age and the majority, 63%, are single. In relation to the number of children they have, 30% have one, 28% two, 22% three, 7% four and 13% more than four. Most of the children, 68%, are between zero and 11 years old[34]. The prison has a gallery called the Mother and Child Unit - UMI, which annually houses on average 60 pregnant women and 25 mothers accompanied by their children. The prison welcomes pregnant women inmates from all over Rio Grande do Sul state from the sixth month of pregnancy on.

In the Pilot Project, the visits were planned and executed by representatives of the State Technical Group, as a way of knowing the reality of the prison system; analyzing the specificities of the target audience; and reflecting on the necessary methodological adaptations; among other aspects. This fact was extremely relevant for the elaboration of a new proposal for this public, assisting different regions of Rio Grande do Sul.

PIM care at Madre Pelletier was performed through the Group Care Modality, regardless of the child's age. This adaptation of the methodology was necessary because individualized care was not possible since the imates live in a shared space. In addition, characterization and monitoring instruments were not used due to the turnover of pregnant women and mothers. The visits were planned in advance, respecting the culture and experience of the participants, and included orientation and play activities to promote child development and healthcare through maternal protagonism. The main objectives of this initiative were: to guarantee access to a public policy for mothers and children, to minimize the vulnerability of the incarcerated population; to stimulate and strengthen the mother-baby bond; to promote healthy integral child development, and to provide healthcare guidance for pregnant women and infants.

A challenge of the Pilot Project was the difficulty in raising awareness of pregnant women and mothers to comply with the proposal, since maternity in prison is often not desired due to the difficulty of facing the arrival of a baby who will be deprived of freedom. In addition, the rotating participation of the detainees, due to transfers, reallocations, and legal procedures; the lack of adequate setting for baby care, coupled with fragile security were also relevant aspects for this initiative.

After five years of experience, the construction of the "Maternal and Child Intersectoral Care Line" began in 2017, aimed at three prisons exclusively for female inmates or ex-convicts in Rio Grande do Sul and their children under the age of four. It is featured by visitation to incarcerated children, women, and infants. It includes visitation of the child and their mother/

34 Research developed by the Operational Support Center for Children, Youth, Education, Family and Succession and by the Criminal Justice Prosecutor's Office of Porto Alegre. Available at: https://www.mprs.mp.br/noticias/id39558.htm

caregiver during their stay in prison and the continuity of visitation during the process of reinsertion of the child into the extended family/community. The project involves all children under four years old with a mother coming from or exiting exclusively female prisons and residents in the municipalities of Porto Alegre, Torres, and Guaíba, and will be developed as a line of action of the Primeira Infância Melhor Program, which is part of the health networks of the municipalities of the state of Rio Grande do Sul. The project stages include the following actions geared toward promoting the development of children from 0 to 3 years old whose mothers have been incarcerated:

- Survey of pregnant women and women with children up to 4 years of age, incarcerated in pre-trial detention;
- Mapping of services that make up the network of intersectoral care for women and children from the three prisons;
- Agreements with local municipal, state and federal authorities, including the municipal education, social assistance, and healthcare networks;
- Employee selection for supervision, network articulation, and visitation;
- Formation of selected Visitors;
- Evaluation of physical structures and female prisons;
- Adaptation of the structures with the creation of a specific room for the execution of the project in the three prisons;
- Adaptation of the physical place in the prison where the babies remain respecting national health regulations, seeking the guarantee of the right to development in a healthy environment;
- Initial Primeira Infância Melhor activities for pregnant women, mothers, and infants in three female prisons in the individual and group modalities, from pregnancy to the permanence of the infants in the prison;
- Beginning of PIM home visit within the process of insertion of the baby into the extended family and of children under 4 years of age along with the mother that came from the exclusively female prisons and who resides in the municipalities.

2. International Early Childhood Seminar

Year	Subject	Main speakers
2003	The global and Brazilian experience in the integral development of early childhood	J. Kevin Nugent – USA Emily Fenichel – USA Bruna Giacopini – Italy Mary Young – USA Liliana Mayorga Salas – Chile Maria Guadalupe Rodríguez Martínez – Mexico José Ovidio C. Waldemar - Brazil
2004	Emotional development during early childhood: basic presuppositions for learning	Thomas Berry Brazelton – USA José Amar Amar – Colombia Vital Didonet – Brazil Osmar Gasparini Terra – Brazil Marcos Fuchs – Brazil Isabel Rios – Cuba Battista Quinto Borgui – Italy Alessandra Schneider – Brazil

Year	Subject	Main speakers
2005	The family environment in child development	Salvador Célia – Brazil Jaderson Costa da Costa – Brazil Jairo Alberto Zuluaga Gomes – Colombia Angela Nunes – Portugal Rubens Alves – Brazil Anna Lúcia Campos – Peru Maria Guardalupe Rodriguez Martínez – Mexico Maria Auxiliadora González – Venezuela Marylin Benoit – USA Anne Frichet – France Gaby Fujimoto – USA Humbert Montagner – France
2006	The economic impact of early childhood	James Heckman – USA Fraser Mustard – Canada Soo Choi – France Rosane Silva Pinto de Mendonça – Brazil Maria Madalena Santos – Brazil Alessandra Schneider – Brazil Francisca Maria Andrade – Brazil
2007	A policy for violence prevention and early childhood in the State of RS	Vital Didonet – Brazil Maria Inés Cuadros – Colombia Myrtha Chokler – Argentina Bernard Golse – France José Ottoni Outeiral – Brazil Vitor Mardini – Brazil Dominic Berter – Brazil Saul Cypel – Brazil Isabel Rios – Cuba
2008	Early childhood care and its impact on the reduction of poverty and violence	Christopher Clouder – England Richard Tremblay – Canada Jorge Kayano – Brazil Alina Gómez Flórez – Colombia Francisco Carrión – Ecuador Mary Eming Young – USA Magdalena Janus – Canada Alberto Concha – Brazil Miriam Diaz – Cuba Fraser Mustard – Canada

Year	Subject	Main speakers
2009	Innovative care models for early childhood	Steven Barnett – USA Ellen Claire Frede – USA Antenor Naspolini – Brazil Lúcia Grigolletti – Brazil Miguel Zabalza Beraza – Spain Vitor Guerra – Uruguai Jon Korfmacher – USA David Dickinson – USA Bernardo Castro – USA Juan Jose Ortiz – Cuba
2010	Investment in early childhood - reality and evidence	Paolo Fontani – Italy Leonardo Yánez – Netherlands Sinane Reynaldo Goulet – USA Agnès Szanto – France Jonathan Richard Henry Tudge – USA Nicholas David Wechsler – USA Myrtha Chokler – Argentina Maite Onochie – Spain Marilena Flores Martins – Brazil Marcos Kisil – Brazil
2011	Childhood and health: care lines and care integrality	Abraham Hersz Turkenicz – Brazil Adriana Friedmann – Brazil Angél Martinez – Espanha Fernanda Ramos Luz – Brazil Herve LeGuillouzic – France Leonardo Yánez – Netherlands Lori Roggman – USA Maria Thereza Marcílio – Brazil Ricardo Paes de Barros – Brazil Victor Guerra – Uruguai
2012	Being a baby: the inalienable right of every child	Sandra del Rócio – Ecuador Paulo Bonilha – Brazil João Batista – Brazil Leandro Pinheiro – Brazil Marcela Aracena Alvares – Chile Clarissa Aliatti Beleza – Brazil Fernando Anschau – Brazil Angelita Hermann – Brazil

Year	Subject	Main speakers
2013	The child in the territory: everyone's commitment	Celso Gutfriend – Brazil Cristina Loyola – Brazil Eric Duku – Canada Liliane Penello – Brazil Dora Ruiz – Peru Miriam Diaz Gonzales – Cuba Tião Rocha – Brazil Carmem Oliveira – Brazil
2014	Playfulness as an essential human development activity	Vitor Guerra – Uruguai Ana Cláudia Leite – Brazil Alemberg Quindins – Brazil State Technical Group Members

Source: PIM website (www.pim.saude.rs.gov.br), 2017.

Carla Naíne Martins - *Family cared for by PIM*
When the Visitor arrived, the whole family was involved to transmit the acquired knowledge to the baby. It was so fun and gratifying to feel that my daughter gradually responded to the stimuli. The program tightened the bond of closeness between us, which strengthened our family ties.

Angela Lopes - *Indigenous Visitor Rio da Várzea - Liberato Salzano/RS municipality*
With our efforts there are more healthy children. It was hard for me at first. We had to orient the activities for them to do and to participate in all the activities. Through that, I am very happy because the children are learning a lot.

Eduardo de C. Queiroz - *President and Director of the Maria Cecilia Souto Vidigal Foundation*
This publication can contribute to the improvement of public policies focused on early childhood and we hope that this book can be an inspiration to other countries, states, and municipalities that wish to prioritize this important stage of life in their policies and programs. We congratulate PIM for the initiative and thank you for all these years of partnership.

Leonardo Yánez - *Senior Representative of the Bernard van Leer Foundation*
PIM is an equalizer of opportunities, a Program that believes in the power of the family to overcome inequalities. PIM is a model that has been adapted to other regions of Brazil and has been inspiring solutions to the serious problems of inequality that still affect this great nation.

Liliane Penello - *Coordintator of Estratégia Brasileirinhas e Brasileirinhos Saudáveis/Ministry of Health*
The proposal of coordinated approximation of the social facilities of the territory and the concern to articulate the challenges of micro and macro policies, translating them into effective actions for integral attention, are highly positive highlights of this initiative that we applaud.

Gilvani Pereira Grangeiro - *Technical Adviser to the General Coordination of Child Health and Breastfeeding/Ministry of Health*
I highlight three aspects of PIM: their experience, the intersectoral performance, and their availability in sharing knowledge. PIM has gone beyond the limits of Rio Grande do Sul and is willing to pass on knowledge and shorten the path of those who want to start.

Katherine M.M. Benevides - *State Coordinator of Child Healthcare for the State of Amazonas*
We had great challenges in the Amazon. The first one was to try to "adapt" the successful PIM to the reality of the Amazon; the second was for the PIM team to travel across Brazil and support this construction. The PIM team embraced this challenge along with us.

Alessandra Schneider - *Psychologist, Technical Assistant to the National Board of Health Departments (CONASS)*
Through all the learning generated, after nearly fifteen years of implementation, PIM has been recognized in Brazil and abroad as a good practice of integral care for young children and their families. Congratulations to all who daily build this reality.

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