

JAEI GOLDSMITH WEIL

MILK MAKES STATE:  
THE EXTENSION AND IMPLEMENTATION OF CHILE'S STATE MILK PROGRAMS,  
1901-1971<sup>1</sup>

---

ABSTRACT

Since the early 20<sup>th</sup> century, Chile has responded to high indices of infant mortality and malnutrition with programs that distribute milk to families in exchange for their maintenance of a preventative healthcare program. This article outlines the background and extent of these efforts, tracking their institutionalization from charitable initiatives to a universal right as of 1954. During the government of Eduardo Frei Montalva (1964-1970) in the context of a progressive communitarian health project, local clinic workers would go door-to-door recruiting mothers to become beneficiaries. For many women, neither formal workers nor habitual voters, these encounters were their first with the state. The article relies on site-intensive research and in-depth interviews with experts, service providers and families to trace how state expansion was experienced at the local level.

**Key words:** Chile, twentieth century, Public Health Expansion, National Milk Program, Infant-mother Health Care, *Promoción Popular*, Citizen-state Interactions.

RESUMEN

Desde inicios del siglo xx, Chile ha combatido sus altos índices de mortalidad y desnutrición infantil con programas que distribuyen leche a familias que se mantienen al día con un programa de salud preventivo. Este artículo examina los antecedentes y extensión de estos esfuerzos, rastreando el proceso de institucionalización desde iniciativas de caridad a un derecho universal en 1954. Durante el gobierno de Eduardo Frei Montalva (1964-1970), en el contexto de un proyecto de salud comunitario, trabajadoras de consultorio iban puerta a puerta reclutando madres para ser beneficiarias de estos servicios. Para muchas mujeres, que no eran trabajadoras formales ni votantes habituales, estos encuentros se constituyeron en sus primeros contactos regulares con el estado. Este artí-

---

\* Ph.D. in Political Science, Northwestern University, 2014; Master of Public Affairs, University of Texas at Austin, 2003. Académica de la Universidad Central de Chile. Correo electrónico: jael.goldsmith@ucentral.cl

<sup>1</sup> El artículo ha sido elaborado con el financiamiento del proyecto CONICYT FONDECYT posdoctorado N° 3140116. Una versión anterior de este proyecto fue presentado en el Congreso de Latin American Studies Association 2015 y se agradecen los excelentes comentarios de Jadwiga Pieper Mooney y Mary Rose Kubal en esta ocasión. Se extiende un agradecimiento especial a Isabel Castillo por sus aportes intelectuales, atención al detalle y generosidad con la asistencia en la preparación del manuscrito final. Se recuerda al Dr. Alfredo Goldsmith Pecher por su compromiso con la salud pública:

culo se basa en un trabajo de campo intensivo en dos consultorios y utiliza entrevistas en profundidad a expertos, proveedores de servicios y familias para trazar cómo la expansión estatal fue vivenciada en el ámbito local.

**Palabras claves:** Chile, siglo xx, salud pública, Programas de Leche, salud materno-infantil, promoción popular, extensión de ciudadanía.

Recibido: Mayo 2015.

Aceptado: Abril 2016.

## INTRODUCTION

The *Programa Nacional de Alimentación Complementaria* /National Program for Complementary Foodstuff (PNAC), which distributes milk to families in exchange for keeping up to date with a preventative healthcare program, was initiated in 1954. From early on in the 20<sup>th</sup> century, infant (mal)nutrition and high mortality rates had been at the core of discussions amongst political authorities and the medical community and in this context, increasing milk consumption was seen as the “optimal modern solution”. The first initiatives to distribute milk to the poor were private and charity-based; but the state became increasingly involved, culminating in the institutionalization of the PNAC in 1954. During the government of Eduardo Frei Montalva (1964-70), in the context of progressive communitarian health projects, coverage became extensive. The expansion of public milk provision relied on state efforts on two fronts: from the demand side, it required extending its bureaucratic capacity to reach the population and persuading citizens to use these services, and from the supply side, the state had to foster the development of the milk industry.

The central argument of this article is that the development and evolution of state milk programs –which are still underexplored in the literature, provide a window for analyzing the development of the Chilean state in the 20<sup>th</sup> century. The transition from private to public provision exemplifies the growth of a proto-welfare state; the implementation of the program reflects the strengthening of the state’s bureaucratic capacity; and the measures to support the dairy industry shed light on the attempt to have a developmental state. The areas of state development discussed in this article constitute key dimensions of state involvement during the period under analysis. In fact, the success of the PNAC –in place until today–, in terms of coverage and durability, constitutes an example of the strength of the Chilean state by comparative standards<sup>2</sup>. In addition, and a central contribution of this article, is that this top-down perspective on state building is complemented with thick descriptions of everyday citizen-state interactions.

The article relies on grass-roots and expert (doctor and politician) interviews conducted between 2011-2013. It uses site-intensive observation methods zooming in on two health centers in different Santiago neighborhoods. The selected neighborhoods –Macul and Recoleta<sup>3</sup>– were chosen because their inhabitants were neither wealthy

---

<sup>2</sup> See Hillel Soifer, *State Building in Latin America*, Cambridge-NY, Cambridge University Press, 2015.

<sup>3</sup> Permissions for conducting interviews within clinics in the municipalities of Recoleta and Macul were attained through municipal and Ministry of Health authorities.

enough to opt out of the PNAC program nor poor enough to qualify for narrowly targeted means-tested programs, and were located in different quadrants of the city. Interview templates were semi-structured open-ended and focused on their memories of the PNAC program, the ways families received these programs, resisted and/or demanded changes<sup>4</sup>. The interviews were complemented by archival research on official documents and statistics, and by secondary literature, in particular with an extensive literature review of texts produced and supervised by Chilean historians who are most knowledgeable on these matters.

This article is part of a research project that uses Chile's infant-maternal primary healthcare services as a prism to trace the informal strategies deployed by citizens and local service providers throughout three combinations of political, economic, and welfare regimes. Tracing the implementation of one state program is used as an illustration that maps the trajectory of the Chilean social state through three distinct periods. This text focuses on the first of these periods, which spans from the early 20<sup>th</sup> century to 1971, reviewing the antecedents to Chile's milk programs. It begins by situating the topic in a comparative framework, reviewing the antecedents to the PNAC from 1901 to 1954 and early state-led efforts to address problems of milk underproduction and unsanitary production conditions. From here, it shifts to examine the infrastructural conditions for milk expansion, addressing public policies to increase domestic industrial dairy production. The article then proceeds to examine the ground-level mechanisms through which the extension of the milk program occurred focusing on the creation of bonds between families and local clinics, which are their first linkage to the public health network. It concludes with a brief discussion of the long-term effects of this unique process of incorporation under state auspices via the PNAC.

#### STATE-LED NUTRITION PROGRAMS IN COMPARATIVE PERSPECTIVE

The decades following the Great Depression marked the beginning of the process of industrialization in most Latin American countries, and with it, the expansion of the state. The model of industrialization was import substitution, known as ISI, where the state had a central role. This process of industrialization was embedded in a larger question regarding what it meant being a modern nation. Achieving the ideal of a modern country

---

<sup>4</sup> Experts gave the author explicit permission to use their names. Family and provider interviewees were asked to choose the pseudonym under which they wished to appear in subsequent publications. Those interviewees who did not have a preference or where we did not have a chance to discuss them are assigned pseudonyms by the author. Family interviews were intergenerational when possible (mostly to senior citizens) and included memories of their time as milk recipients as young children, parents, grandparents, and in some cases great grandparents of young children (1930's-2010). Following the model of Edin and Lein, and with attention to the need to create a context of trust, families were contacted through my participation in neighborhood organizations, personal introductions and in face-to-face encounters. After that, I used snowballing techniques to broaden my scope, asking interviewed families to introduce me to additional families in the neighborhood. Kathryn Edin and Laura Lein, *Making Ends Meet: How Single Mothers Survive Welfare and Low-Wage Work*, New York, Russell Sage Foundation, 1997.

boosted the state's involvement in an increasing number of areas, including the attempt to regulate gender and family relations<sup>5</sup>.

The health of the population was a central concern in this context, since a healthy population was necessary for productive activities<sup>6</sup>. Sandra Aguilar has narrated how in the Mexican case, in the 1940's and 1950's the elite became increasingly concerned with the diet of the lower classes<sup>7</sup>. The medical community was particularly concerned with the caloric intake and its contents, trying to incentivize the consumption of meat and milk, uncommon foods in a Mexican diet based on corn, beans, and chili. The process of nutritional education was largely carried out by nurses that would provide information on a door-to-door basis and the professionalization of nursing is directly linked to this process<sup>8</sup>.

Women, as mother and caretakers, played a central role as recipients in the state's effort to promote better nutrition and health conditions; they also participated in temperance campaigns<sup>9</sup>. In the Southern Cone, puericultura, the medical branch concerned with early childhood care, became a central concept among women as governments attempted to introduce scientific notions for improving population health standards<sup>10</sup>. The specifics of how and when women and families became the object of the state's disciplinary efforts varied according to the particular political, social, and nutritional context of each country. These processes that were occurring in Chile and the rest of Latin America form the backdrop of state milk programs discussed in this article.

#### SPEARHEADING STATE MILK PROGRAMS AND PRODUCTION

Programs that combat infant malnutrition and mortality via milk and preventative healthcare have antecedents in charitable and targeted state programs from the early 20<sup>th</sup> century until in 1954 this benefit became universal. The high levels of infant mortality (one in every four live births in 1920) caused by malnutrition and unsanitary living conditions were public concerns throughout the 20<sup>th</sup> century<sup>11</sup>. This section describes these early initiatives, the political and policy context and briefly addresses state efforts to boost domestic dairy production.

*From private to public:*

---

<sup>5</sup> Karin Roseblatt, *Gendered Compromises: Political Cultures and the State in Chile, 1920-1950*, Chapel Hill-North Carolina, University of North Carolina Press, 2003.

<sup>6</sup> *Ibid*

<sup>7</sup> Sandra Aguilar Rodríguez, "Alimentando a la nación: género y nutrición en México", en *Revista de Estudios Sociales*, N° 29, Bogotá, 2008, pp. 28-41.

<sup>8</sup> *Ibid*.

<sup>9</sup> Jocelyn Olcott, "'Worthy Wives and Mothers': State-Sponsored Women's Organizations in Postrevolutionary Mexico", in *Journal of Women's History*, vol. 13, N° 4, Baltimore, Winter 2005, pp. 106-131. .

<sup>10</sup> Asunción Lavrin, *Women, Feminism, and Social Change in Argentina, Chile, and Uruguay*, Lincoln-Nebraska, University of Nebraska Press, 1998, chapter 3.

<sup>11</sup> Estimates of infant mortality between the 1920-5 and 1950's put this rate between 250 (p/1000 live births) in 1920 and 241.6 in 1935. Dagmar Racynski y Cesar Oyarzo, "¿Por qué cae la tasa de mortalidad infantil en Chile?", en *Colección Estudios Cieplan* 6, N° 55, Santiago 1981, p. 36; Gobierno de Chile, *Nutrición para el desarrollo: El modelo chileno*, Santiago, LOM Ediciones, 2005, p. 36.

*Tracing the institutionalization  
of State Milk Programs*

The first systemic attempt to combat infant malnutrition was initiated in 1901 by a private institution –the Patronato Nacional de la Infancia/ National Patronage of Infancy, founded after an earthquake left hundreds of children homeless in the capital<sup>12</sup>. Inspired by experiences in France, pediatrician Dr. Luis Calvo Mackena spearheaded the creation of neighborhood milk dispensaries –Gotas de Leche/ Drops of Milk<sup>13</sup> that provided periodical medical care and education in addition to milk<sup>14</sup>. By 1912, three centers existed and five were in planning phases for Santiago’s 500,000 inhabitants<sup>15</sup>.

Gotas de Leche combined traditional charitable initiatives –organized by elite women and nuns, with the scientific knowledge of doctors capable of “seeing” reality through statistics<sup>16</sup>. As a pilot experience, the results were extremely promising and it was possible to observe lower infant mortality rates in neighborhoods where there was a Gotas de Leche center: In 1930, infant mortality amongst the 2,573 infants registered with the program was 7,35% compared to 19-23% amongst the general population<sup>17</sup>.

This intervention model, which included “penetration into poor urban neighborhoods” and creating “points of transmission of knowledge on the ‘science of child-rearing’ to popular sectors”<sup>18</sup> became the architecture for what will later become the PNAC<sup>19</sup>. According to Illanes, visitors would “translate” the “normative monologue” of doctors using traditional formats such as oral litanies with consistent repetition, nested in the familiar formats of “advice” and “friendship”. This incorporation of a professional in the role of mediator reflected a particular vision of social medicine where a *visitadora social*/ social visitor, embodied a human face negotiating between science, the state and the poor<sup>20</sup>.

---

<sup>12</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, p. 37; Isabel Pemjean, “Una historia con olor a leche: De la desnutrición a la obesidad, políticas públicas e ideologías de género”, en *Revista Punto Género*, N° 1, Santiago, 2011, pp. 103, 108. For an analysis on state approaches and policies related to childhood in the previous (1850-1930) period, see: Nara B. Milanich, *Children of Fate: Childhood, Class, and the State in Chile, 1850-1930*, Durham, Duke University Press, 2009. For a history of Chilean sanitary programs, see edited volume: María Soledad Zárate Campos (ed.), *Por la salud del cuerpo: Historia y políticas sanitarias en Chile*, Santiago, Ediciones Universidad Alberto Hurtado, 2008.

<sup>13</sup> Known as *Gouttes de Lait* in France. For more on these, see Deborah M Valenze, *Milk: A Local and Global History*, New Haven, Yale University Press, 2011, pp. 215-218. For a history of changing visions and policies on feeding infants, see: María Soledad Zárate Campos, “‘El licor de la vida’. Lactancia y alimentación materno-infantil en Chile, 1900-1950”, en Carolina Sciolla, *Historia y cultura de la alimentación en Chile*, Santiago, Catalonia, 2010, pp. 235-262.

<sup>14</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, p. 37; Maria Angelica Illanes, *Cuerpo y sangre de la política: La construcción histórica de las visitadoras sociales (1887-1940)*, Santiago, LOM Ediciones, 2007, pp. 137-139.

<sup>15</sup> Illanes, *op. cit.*, p. 139.

<sup>16</sup> *Op. cit.*, p. 137.

<sup>17</sup> *Op. cit.*, p. 306.

<sup>18</sup> *Op. cit.*, pp. 139-140.

<sup>19</sup> *Op. cit.*, p. 306.

<sup>20</sup> *Op. cit.*, pp. 211, 215-216, 139-140. For more on this, see Pemjean, *op. cit.*, p. 109; Teresa Valdés y Marisa Weinstein, *Mujeres que sueñan las organizaciones de pobladoras en Chile: 1973-1989*, Santiago, Facultad Latinoamericana de Ciencias Sociales FLACSO, 1992, p. 47.

The other central characteristic of these programs was that material benefits were often conditional and in the eventual PNAC, milk was destined for those families able to keep up to date with a preventative healthcare program. In these early initiatives, for example, benefits were tied to particular actions such as the attendance of informational talks; and on Christmas day, “behavior prizes” were given to those mothers who had breastfed longest, attended the clinic with most regularity or demonstrated hygienic behavior with their children<sup>21</sup>. Those mothers who were considered faulty recipients, by cause of death of their infants, non-attendance to medical controls, or tardiness, were threatened with expulsion from the program.

The initiative managed to capture the attention and sympathies of political elites who saw it as a project in alignment with “civilized societies” and with time, the state adopted these ideas of milk-for-care programs that charitable initiatives had begun experimenting with. The inauguration of the first dispensary in 1911 was attended by Liberal Party Member President Ramón Barros Luco and it was highlighted at the 1912 First National Congress for the Protection of Infancy. The Senate gave the dispensary a fixed assignment with which it was able to purchase state of the art technology from Europe: “A magnificent sterilizer for milk in glass bottles, a machine that washes bottles, wire baskets, scales for newborns, etc., as well as a luxurious iron bathtub with the installations for heating water, a drug dispensary with its accessories”<sup>22</sup>.

Accompanying this process that channeled efforts through the state, the National Patronage of Infants made attempts to “professionalize” their work, transferring responsibility from charitable elite women to a new class of female professional public servants. In 1924, the Patronage created what was known as a “Cuerpo de Señoras/Body of Ladies”, destined to redirect elite women’s previous charitable efforts<sup>23</sup> and professionals from Chile’s newly created School of Social Work were incorporated as permanent staff members<sup>24</sup>. Volunteers were relegated to those tasks considered less demanding of technical expertise, such as bathing infants and distributing bottles and were not sent on home visits.

In the political terrain, during the first decades of the 20<sup>th</sup> century Chile’s political elite engaged in heated debates on what was defined as “La Cuestión Social/ The Social Question” referring to the need to create health and sanitary services for the poor<sup>25</sup>. During Liberal Party member Arturo Alessandri Palma’s presidency (1920-5), these debates were accompanied by the creation of a public health apparatus<sup>26</sup>. Alessandri had

---

<sup>21</sup> Illanes, *Cuerpo y sangre...*, *op. cit.*, pp. 140, 201-202.

<sup>22</sup> *Op. cit.*, p. 138.

<sup>23</sup> *Op. cit.*, pp. 303-305; Pemjean, *op. cit.*, pp. 108-109.

<sup>24</sup> *Op. cit.*, pp. 295, 304.

<sup>25</sup> María Angelica Illanes, “*En el nombre del pueblo, del Estado y de la ciencia, (...) historia social de la salud pública Chile 1880-1973 (hacia una historia social del siglo xx)*”, 2<sup>a</sup> edición, Santiago, Ministerio de Salud, 1993.

<sup>26</sup> Health services were slowly expanded in a top-down corporatist fashion creating over 160 often overlapping separate programs and agencies. Joseph Collins and John Lear, *Chile’s Free-Market Miracle: A Second Look*, Oakland, California, A Food First Book, 1995; Stephan Haggard and Robert R. Kaufman, *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*, Princeton, Princeton University Press, 2008. In terms of the public healthcare, Chile was reputed as a regional pioneer

won elections based on promises to address the “social question”<sup>27</sup> and during his presidency private efforts at combating malnutrition began to be channeled through the state. The Ley del Seguro Obrero Obligatorio/ Worker’s Obligatory Social Insurance Law (Law N° 4.054<sup>28</sup>) passed in 1924 was a comprehensive set of laws regulating working conditions which amongst other issues committed medical services and milk for working mothers<sup>29</sup>.

During Alessandri’s second presidency (1932-8), Minister of Salubrity Dr. Eduardo Cruz-Coke Lassabe argued to extend the program claiming that while national rates of infant mortality had not improved in the ten years since the implementation of the Worker’s Social Insurance Law (237.5 p/1000 in 1925 and 241.6 p/1000 in 1935, see figure 1), there were improved results amongst those families insured by the Worker’s Insurance Fund<sup>30</sup>. In addition to the “scientific arguments,” this was a popular program and it is said that much of Alessandri’s popularity is due to the progressive public health policies suggested by Minister Cruz-Coke<sup>31</sup>.

Information on modern puericulture techniques was delivered by female volunteers and professionals and presented in formats intended to cross boundaries and create empathy. The daughter and mothers interviewed in this project recall visits as “fun outings with their mothers and aunts”. For example, Maria, Macul resident recalls accompanying her mother and aunt to the Seguro Obligatorio and Gotas de Leche as fun field trips when she was a child. Empty jars of condensed milk needed to be returned and her favorite part was placing them on top of what she recalls as a “huge tower” of empty cans<sup>32</sup>, and help her aunt make cookies with the ingredients and recipes she got

in the widespread extension of high quality health services and by the 1970’s, Chile had the region’s second-highest social policy coverage. Christina Ewig and Stephen J. Kay, “Postretrenchment Politics: Policy Feedback in Chile’s Health and Pension Reforms”, in *Latin American Politics and Society*, vol. 53, N° 4, Miami, 2011, Filgueira describes it as an almost-universal social state. Fernando Filgueira, *Past, Present and Future of the Latin American Social State: Critical Junctures and Critical Choices*, UNRISD, 2005. Benefits were skewed towards historically well-organized enclaves, urban sectors and middle-class constituencies. Ewig and Kay, *op. cit.*, p. 74.

<sup>27</sup> In an electoral speech that according to Arellano swung the election, he declared that it was the obligation of the state to provide the conditions necessary to safeguard the physical, moral, and intellectual integrity of the poor. José Pablo Arellano, *Políticas sociales y desarrollo: Chile 1924-1984*, Santiago, CIEPLAN, 1985, pp. 27-28.

<sup>28</sup> A comprehensive set of laws regulating working conditions. This law was based on a project presented in 1921 by doctor and senator Exequiel González Cortés who was inspired by the public health system installed in Germany by Chancellor Von Bismark. Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 40-41.

<sup>29</sup> This benefit was extended to pregnant women and those with infants up to eight months old and included milk distribution for mothers who did not breastfed. For more on the infant-maternal services provided via the workers social insurance law, see: María Soledad Zárate Campos y Lorena Godoy Catalan, “Madres y niños en las políticas del Servicio Nacional de Salud de Chile (1952- 1964)”, en *História, Ciências, Saúde-Manguinhos*, vol. 18, N° 1, Rio de Janeiro, 2011, pp. 131-151.

<sup>30</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 38, 42.

<sup>31</sup> This argument is made by Arellano, *op. cit.* This also came up in my interviews of Christian Democrat Senator Dr. Mariano Ruiz-Esquide (December 22, 2011) and prominent public health specialist Dr. Francisco Mardones Santander (July 26, 2013).

<sup>32</sup> “What I most remember is that my Mother always went to the Seguro, the Seguro Obrero, Seguro Obligatorio as it was called in that time. I remember perfectly because the milk they would give us was condensed milk. ...I would like to go, because there were lots of people, lots of ladies with their babies... So you

at Gotas<sup>33</sup>. Once she became a mother, she also used milk-for-healthcare programs and recounts how she learned how to care for her children at the Caja de Empleados Particulares/ Private Workers Fund clinic<sup>34</sup>.

After a successful one-year trial extension of the Worker's Insurance Fund<sup>35</sup>, the Alessandri/Cruz-Coke duo sent a law to congress for approval<sup>36</sup>. The proposed resolution known as the Ley de la Madre y el Niño/ Mother and Child Law was approved during the presidency of Radical Party member Pedro Aguirre Cerda (1938-1941). It extended services to the wives of working men, committing dairy supplements and medical care to all affiliated workers with infants under the age of two<sup>37</sup>. The implementation of this law signified an effective enormous leap in coverage and had visible results. After a decade of implementation infant mortality had dropped from 235 p/1000 (1938) to 160 p/1000 (1948) (see figure 1). In 1939, Minister of Salubrity Dr. Salvador Allende – a supporter of what he referred to as “social medicine”- created the Dirección Central de la Madre-Niño/ Central Office for the Mother-Infant within the Health Ministry<sup>38</sup> and lobbied to streamline public health programs into one national service (a project which would take ten years to be approved).

By the 1950's, public interventions aimed at mothers and infants had significantly helped to decrease infant mortality and malnutrition rates. However, these figures, which had halved, hit a slump around 110 and were still alarmingly high relative to the region<sup>39</sup>. At the same time, infant malnutrition continued to be one of Chile's main

had to return the empty jars and there was a pile of jars. So I would bring a bag with my empty jars and we would take home full ones... So one would leave the empty jars there, and I would love it. Because you got to climb on this pile of empty jars to add yours and they would all tumble down”. Personal interview, Macul home, December 14, 2011.

<sup>33</sup> “They gave her classes on how to prepare the milk and how to prepare the oatmeal cookies. I always remember that, she went to workshops on how to make cookies. My aunt would come home and start making them with the milk cream ... and I would bring out the little pot, the corn starch, the milk with the spoon, the bottle and strainer”. *Ibid.*

<sup>34</sup> “My mother died when I was around 18 or 20, years before getting married... So how did I learn? Well, because I got guidelines when I would take my kids to the clinic of course: To always boil milk, I mean boiled water, clean hands, to sterilize the bottle – all of those things I learned at the clinic”. *Ibid.*

<sup>35</sup> Positive results in terms of women standing in long lines to receive services.

<sup>36</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 44-45.

<sup>37</sup> *Ibid.*

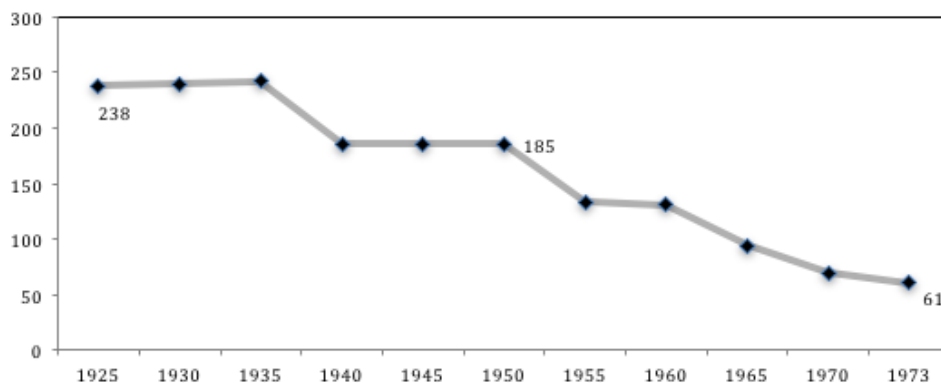
<sup>38</sup> Pemjean, *op. cit.*, pp. 110-111; Mariela Aguilera y Carla Zúñiga, *Políticas estatales de asistencia social en Chile: el Problema de la Leche, 1930-1970*, tesis para optar al grado de Licenciatura en Historia, Santiago, Universidad de Chile, 2006, p. 52. In spite of the economic crisis that made putting some of their more progressive measures in place difficult, Allende managed some significant advances including the installation of “milk bars”. Milk bars were initiatives aligned with temperance movements and also implemented in other countries. For discussion and images of milk bar initiatives in other countries where dairy products were served, see: Valenze, *op. cit.*

<sup>39</sup> Racynski y Oyarzo, *op. cit.*, p. 36. According to some accounts, these numbers can best be understood as Chile having the “worst best statistics” referring to the fact that due to the centralized nature and extension of the state, data gathering mechanisms were more developed than some neighboring countries whose official numbers might under-represent the situation lived in areas less reached by the state. By 1960, infant mortality was 120.3 p/1000 live births compared to 62.4 in Argentina, 47.4 in Uruguay and 92.1 in Peru. Tarsicio Castañeda, “Contexto socioeconómico y causas del descenso de la mortalidad infantil en Chile”, en *Estudios Públicos*, Nº 16, Santiago, 1984.



health problems and 80% of pediatric beds in hospital wards were occupied by children under the age of two with severe malnutrition<sup>40</sup>.

FIGURE 1  
*Infant Mortality in Chile, 1925-1973*  
(p /1000 live births)



Sources: Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*; Racynski y Oyarzo, *op. cit.*, pp. 45-84; UN Inter-agency Group for Child Mortality Estimation released the latest estimates on child mortality ([www.childmortality.org/](http://www.childmortality.org/)) accessed October 2013.

In addition to these alarming figures, there was a consensus beyond political alliances amongst doctors—a close-knit group<sup>41</sup>, on the need to intervene and advocate for services delivered at the local level. According to Dr. Jorge Jiménez de la Jara, by the 1950's the “field visits” to marginal neighborhoods pediatrics began to be constructed as a social entity<sup>42</sup>. Doctors were socialized and sensitized at universities and through programs organized by the Servicio Nacional de Salud/National Health Service (SNS). Professors were staunch defenders of the public system, sometimes going so far as to forbid students from working in the private sector<sup>43</sup>. Freshly graduated doctors were encouraged to work as general practitioners in remote regions in exchange for positions and scholarships to pursue specializations. Therefore, the impetus for these programs was strengthened by the consensus amongst medical professionals on both the need for the public expansion of neighborhood-based primary health services and their willingness to provide them.

<sup>40</sup> Fernando Mönckeberg Barros, “Prevención de la desnutrición en Chile. Experiencia vivida por un actor y espectador”, en *Revista Chilena de Nutrición*, vol. 30, N° 1, Santiago, 2003.

<sup>41</sup> For good revision on history and important doctors in this process, see Dr. Carlos Antonio Molina Bustos, “Antecedentes del Servicio Nacional de Salud. Historia de debates y contradicciones. Chile: 1832-1954”, en *Cuadernos Médicos-Sociales*, vol. 46, N° 4, Santiago, 2006; Gobierno de Chile, *Tarjeta de presentación: situación de la salud en Chile 1996*, Santiago, Ministerio de Salud, 1996.

<sup>42</sup> Health Minister (1990-1992) and professor. Personal interview, School of Public Medicine Pontificia Universidad Católica de Chile, July 26, 2013.

<sup>43</sup> Senator Mariano Ruiz-Esquide, as he fondly recalls his professor Dr. Hernán Alessandri Rodríguez (brother of President Jorge Alessandri). Personal interview, former Senate dependencies, December 22, 2011.

The final legal expansion of the program occurred during the government of General Carlos Ibañez del Campo (1952-1958), an outsider to Chile's traditional political parties with a turbulent political biography<sup>44</sup>, who by his second presidency had garnered an unlikely group of supporters including popular sectors, conservative agrarian elites and feminist groups. Starting in 1954, two years after the creation of the SNS<sup>45</sup>, and under the impulse of Minister of Health Dr. Jorge Mardones Restat, the PNAC was created. The biggest change was that benefits were no longer linked nor limited by the occupation of parents and the extension to children up to the age of six<sup>46</sup>. The flip side of the creation of state milk programs was the increasing need to also secure quality milk and the following paragraphs discuss these state efforts.

### *Resolving "El problema de la leche"*

In the early 20<sup>th</sup> century, what was defined as "El Problema de la Leche/The Milk Problem" referred to its scarcity, poor quality, high price and low consumption rates, became a central concern for the Chilean state. Production was limited by the scarce presence of specialized cattle and abysmal sanitary conditions producing low levels of output which often arrived to points of sale decomposed after lengthy time transportations<sup>47</sup>. These problems were so severe that consuming milk presented a significant health hazard. To illustrate, an analysis conducted in 1905 by the "Laboratorio Químico Municipal de Santiago/Santiago Municipal Chemistry Lab" sampled milk sold at various types of locations and found it to be extremely contaminated, with over half (62%) deemed as either mediocre or bad<sup>48</sup>. Not only was milk unsafe; Chilean milk also had a low fat content, providing less than standard nutritional value. Non-optimum feeding practices, stable and milking conditions, in conjunction with the skimming that occurred during transport and the common practice of sellers of adding (sometimes unclean) water or cornstarch to increase volume created milk that had approximately 2.3% fat content versus 3 to 3.5% in the rest of the world<sup>49</sup>.

From the beginning, the process of creating incentives for production in order to secure state milk was deeply tied to public health initiatives and the expansion of social services. The 1925 creation of the Servicio Nacional de Salubridad<sup>50</sup> coincided with the establishment of the Ordenanza para el Expendio de la Leche y sus Derivados/ Dairy Products Ordinance that regulated the sanitary aspects of milk production. Law 4869 included guidelines for sanitation, pasteurization<sup>51</sup>, packaging and price-fixing. In addi-

---

<sup>44</sup> Including aiding in military coups (1925), exiling and imprisoning political opponents, using his position as Minister of State to bully two presidents into resignation before term and being backed by Nazi and Fascist parties.

<sup>45</sup> For exploration of the limitations of the expansion of the SNS between 1952-1964, see: Zárate and Godoy, *op. cit.*

<sup>46</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 43-44.

<sup>47</sup> Aguilera y Zúñiga, *op. cit.*, pp. 26, 28, 38.

<sup>48</sup> Out of 283 samples, only 107 were found to be in "good conditions". Aguilera and Zúñiga, *op. cit.*, p. 34.

<sup>49</sup> Aguilera and Zúñiga, *op. cit.*, pp. 38-39.

<sup>50</sup> Prior to the Servicio Nacional de Salud.

<sup>51</sup> For more on politics of pasteurization in other contexts, see Alan Czaplicki, "Pure Milk is Better Than

tion to these regulations and norms, the state committed to facilitate loans, credits, fiscal subsidies for expenses and investments in the implementation of new installations and made efforts to secure milk at lower prices for impoverished sectors<sup>52</sup>. While between 1907 and 1938, consumption rose significantly from an estimated 35.1 annual liters per capita to 50.5<sup>53</sup>, this was still extremely low in comparative terms; Argentina had a per/capita annual consumption of 250 liters, France and the United States one over 300 liters while Switzerland and the Netherlands' consumption surpassed 500 liters, over 10 times more than the Chilean case<sup>54</sup>.

In 1937, Decree number 384 of the Ministry de Salubrity defined dairy products as first-need articles establishing a link between infant mortality and the "inappropriate" nutritional intake of mothers who were therefore not able to breastfeed<sup>55</sup>. In the same year (1937), Decree number 80 created the Consejo Nacional de Alimentación/ National Council of Foodstuffs which defined its largest challenge as that related to milk production and proposed measures that included the availability of low interest loans via the Caja de Crédito Agrario/ Agrarian Credit Fund, measures to stimulate agricultural exports organized by the Junta de Exportación Agrícola/ Agricultural Export Council and measures aimed at increasing production and yield via the Caja de Colonización Agrícola/ Agricultural Colonization Fund<sup>56</sup>. In 1945, Law number 8094 and Regulation 579 "Sobre Fomento Lechero/ On Promotion of Milk Production", which was financed through a special tax on non-alcoholic beverages, put in place additional measures to approach "The Milk Problem"<sup>57</sup>.

In 1934, Nestlé<sup>58</sup> was the only company which could satisfy state demands for powdered milk and this milk was purchased by the state and distributed through the Obligatory Workers Insurance Fund. In 1937, the Obligatory Workers Insurance fund purchased Chile's first pasteurizing plant; and Minister of Salubrity, Dr. Salvador Allende Gossens created a joint effort with Nestlé to produce condensed milk<sup>59</sup>.

The initial public regulations and direct investment in milk production that have been outlined show how the development of the industry, in a context of state-led industrialization, was tightly linked to the extension of milk programs. Already in the year it was passed (1954), the PNAC program distributed 14 tons of 13% fat milk which had been donated by the United Nations Child's Fund (UNICEF) to the over 500,000 infants and pregnant women registered at primary health clinics through the country<sup>60</sup> and in

Purified Milk'. Pasteurization and Milk Purity in Chicago, 1908-1916", in *Social Science History*, vol. 31, Nº 3, Cambridge, 2007, pp. 411-433.

<sup>52</sup> Aguilera y Zúñiga, *op. cit.*, pp. 41-44.

<sup>53</sup> *Op. cit.*, pp. 40-41.

<sup>54</sup> *Op. cit.*, p. 40.

<sup>55</sup> *Op. cit.*, p. 46.

<sup>56</sup> *Op. cit.*, pp. 44-46.

<sup>57</sup> These included sanitary campaigns, access to credits for the construction and modernization of processing plants, and industrialization processes.

<sup>58</sup> For more on the history of Nestlé in Chile, see: Patricia Arancibia Clavel y Ricardo Arancibia Clavel, *Nestlé, Creciendo con Chile*, Santiago, Nestlé Chile, 2010.

<sup>59</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, 45-46.

<sup>60</sup> In addition to neighborhood clinics and hospitals, milk was directly distributed to the white collar health insurance fund (Servicio Nacional de Empleados/ National Service of Employees, SERMENA), the

1955 the SNS provided services for about 33% of infants (196,507)<sup>61</sup>. Table 1 lists the numbers of reported beneficiaries of the discussed milk programs.

TABLE I  
*Number of Beneficiaries in Milk Programs,  
1900-1973*

Year	Program	Coverage
1930	National Patronage of Infancy	2,573 infants
1935	Worker's Obligatory Insurance Law	5,000 infants
1954	National Program for Complementary Foodstuffs (PNAC)	500,000 mothers and infants
1970	National Program for Complementary Foodstuffs (PNAC)	650,000 mothers and infants
1973	<i>Half Liter</i> Milk Program	3,600,000 children

Sources: Illanes, *Cuerpo y sangre...*, *op. cit.*, p. 306; Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 42-44; Luis Corvalán, *El gobierno de Salvador Allende*, Santiago, LOM Ediciones, 2003, p. 31.

Note: During the time the total population increased and numbers do not represent percentages of eligible beneficiaries.

As table 1 shows, effective coverage was slowly extended during the first part of the 20<sup>th</sup> century and spiked from 1954 onward. This process of extension was accelerated in the late 1960's during the government of Christian Democrat Eduardo Frei Montalva.

#### MILK MAKES STATE: STATE EFFORTS ON THE DEMAND AND SUPPLY SIDE

The years between 1964 and 1970 were characterized by intense popular mobilizations and political polarization. While there were no formal changes in the PNAC program in terms of implementation it is precisely these years when its coverage became effectively augmented into rural and popular urban neighborhoods. The quantity of milk distributed during this period doubled, from 10 million in 1964, doubling to 20 million in 1968<sup>62</sup>, as shown in figure 2.

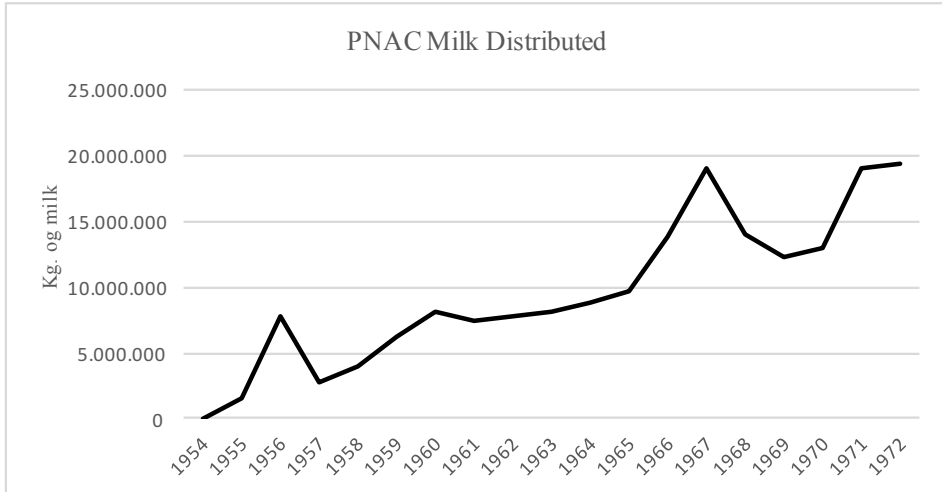
---

armed forces and police, Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, 44. For a review of medical debates on the virtue of distributing milk between 1900-50, see: Zárata, "El licor de la vida"..., *op. cit.*, pp. 253-258.

<sup>61</sup> Zárata y Godoy, *op. cit.*, p. 141.

<sup>62</sup> Jorge Jiménez de la Jara, *Angelitos salvados: Un recuento de las políticas de salud infantil en Chile en el siglo xx*, Santiago, Uqbar Editores, 2009, p. 105

FIGURE 2  
*Distribution of PNAC Milk*



Sources: Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*; Ley de Presupuesto del Ministerio de Salud Pública y Previsión Social para el año 1958; Ministerio de Salud, *Atenciones Externas. Servicio Nacional de Salud*, annual publication, 1957 to 1960; Servicio Nacional de Salud, *Anuario 1961: Atención maternal*, 1961; Ministerio de Salud, *Anuario Atenciones*, annual publication, 1962 and 1963; Ministerio de Salud, *Anuario Atenciones y Recursos. Servicio Nacional de Salud*, 1971; INE, *Estadísticas de Salud*, annual publication, 1970 and 1971.

### *PNAC as a key component of the expansion of public healthcare*

To understand the effective expansion of the PNAC, it is important to situate these efforts within the Christian Democrat's larger project. The Christian Democrats associated themselves with both modernization and moderation; and under the slogan of "revolution with liberty", committed to "re-make capitalism with a human face"<sup>63</sup>. Eduardo Frei Montalva became the first Christian Democrat to win elections in Latin American and his reformist project, which was presented as an alternative to Marxist transformations, pursued progressive though moderate sociopolitical and economic transformations in a context of demands for radical change<sup>64</sup>. By the late 1960's, Chile had become the showcase for the Alliance for Progress<sup>65</sup> and its capital Santiago an intellectual hub for policymakers, politicians, donors and scholars interested in development<sup>66</sup>, housing

<sup>63</sup> Margaret Power, *Right-Wing Women in Chile: Feminine Power and the Struggle Against Allende 1964-1973*, University Park-Pennsylvania, Pennsylvania State University Press, 2002, p. 17.

<sup>64</sup> Jadwiga E. Pieper Mooney, *The Politics of Motherhood: Maternity and Women's Rights in 20th Century Chile*. Pittsburgh-Pennsylvania, University of Pittsburgh Press, 2009, pp. 74-75.

<sup>65</sup> Power, *op. cit.*

<sup>66</sup> Alfredo Goldsmith Pecher, Personal Interview, Santiago, September 22, 1998. In terms of public health programs and services, some extremely progressive social programs were enacted during Frei's presidency –

prominent centers for thought such as the United Nations Economic Commission for Latin America and the Caribbean (CEPAL).

While Frei's signature policies were the "Chilenization" of the copper industry and the Agrarian Reform, the Christian Democrat project also included an element of ground-level mobilization. Promoción Popular/ People's Advancement sought to integrate previously disenfranchised sectors to the state and the nation. It organized marginal and marginalized sectors of society—in particular women and the urban poor—in intermediate bodies (through specific neighborhood-based associations<sup>67</sup>) so they could address their day-to-day problems in collective and state-guided ways<sup>68</sup>.

The entire developmental project required expanding the state apparatus by investing in human capital and infrastructure and in this context, the extension of primary healthcare services was a central part of Frei's Promoción Popular. Former Senator Ruiz-Eskude describes the acceleration of the extension of primary healthcare as a process that gathers force from 1964 on:

"Frei is elected, work begins in '64 and this process is no longer detained ... There was a change of vision. The idea of prevention becomes predominant and that means the appearance of vaccines, of the necessary milk and milk programs, of a concern for mothers, etc. That is the first thing that occurs. Secondly, and as a consequence of this the state makes the health scheme much more consistent. From this point on, we have the concept of 'first level attention' as it was then called (because we only start talking about primary health care after Alma Ata<sup>69</sup>). [...] What was done with this model was create primary attention as we now know it: develop primary attention and develop people's participation which is the basis of primary healthcare"<sup>70</sup>.

The PNAC was at the heart of this mission as can be illustrated by a 1960 document issued by the Ministry of Health where they stated that "Milk distribution is defined by the SNS as one of the most important actions of health promotion that the Institution conducts in its infant maternal policies"<sup>71</sup>.

In order to perform the duties necessary to the successful implementation of the PNAC, the bureaucratic apparatus needed the infrastructure to regularly reach beneficiaries and deliver well-preserved powdered milk (which must then be rehydrated with clean water), as well as the capacity to maintain up-to-date records of citizens. These requirements translated into basic sanitary conditions, roads and census.

For a large portion of the population, in particular the urban poor, these infrastructural conditions did not pre-exist the extension of milk distribution programs. For example,

---

in particular a nation-wide family-planning program. For more on family planning movement, see: Mooney, *op. cit.*, pp. 73, 79, 81-82.

<sup>67</sup> Mooney, *op. cit.*, pp. 75-76.

<sup>68</sup> Sofía Correa, Consuelo Figueroa, Alfredo Jocelyn-Holt, Claudio Rolle y Manuel Vicuña, *Historia del siglo XX chileno*, Santiago, Sudamericana, 2001, p. 240.

<sup>69</sup> International Conference on Primary Health Care, WHO-UNICEF in USSR 1978, 6-12 September 1978. A large emphasis was placed on primary health care.

<sup>70</sup> Personal interview, former Senate dependencies, December 22, 2011.

<sup>71</sup> Ministerio de Salud, *Atenciones Externas. Servicio Nacional de Salud*, Santiago, 1960.

between 1964 and 1970 30% of urban houses lacked electricity and 40% had no running water<sup>72</sup>. Residents in the Recoleta and Macul neighborhoods remember them as basically rural. Marisol, Recoleta resident since 1949 describes the neighborhood as being sold as bare sites without access to running water, electricity or transportation<sup>73</sup>. The narrative of another family also reflects the precarious access to services and remote nature as well as the quest for collective solutions to these challenges, where one old car of owned by a family member had served as an impromptu ambulance for the whole community<sup>74</sup>. Access to basic services was often the product of the bottom-up efforts common at the time, also reflecting the inexistence of previous state outreach. For example, Marisol recalls:

“[...] it took a long time for us to be able to have water and electricity [...] there was a meeting and the neighbor’s association started, and the paperwork was started [...] everything came out of our pockets [...] between all of us”<sup>75</sup>.

Neighborhood-based clinics were often the first public service constructed in the newly urbanizing areas<sup>76</sup> and Dr. Patricio Hevia, Recoleta clinic director in 1970<sup>77</sup>, compares the extension of primary healthcare facilities with the process of colonization (and his role as to that of the country’s conquistadores and founders): “We were like Pedro de Valdivia, Pedro de Valdivia founded cities wherever he went and we founded clinics... When there was a flood, we would put together a clinic to provide aid and then it would stay there”<sup>78</sup>.

The history of specific clinics often illustrates the way top-down and bottom-up impetus combined to effectively expand state services. For example, one Recoleta clinic was created on a site set aside for a nursery school. The community took it over demanding it become a clinic instead. Another stands on a piece of land donated to the community by a wealthy woman from the area. Once sites were assured, the community in conjunction with medical personnel with lobby with the SNS to receive additional

---

<sup>72</sup> Mooney, *op. cit.*, pp. 75-76.

<sup>73</sup> “They sold this by sites, bare sites, just like that. There was no water, there was no electricity. When my husband would come home from work for lunch, my oldest daughter would go out to wait for him rolling a barrel with a large drum with which he would help her haul water home”. Family interview, Recoleta, December 3, 2011.

<sup>74</sup> “I remember that my dad, he had an old junk car. An old little truck, but old. And when some lady was to have a baby they would go and wake him up at two, three in the morning. He was the ambulance here.” The couple interviewed arrived in the area in 1958 and 1946. Family interview, Recoleta, December 1, 2011.

<sup>75</sup> Family interview, Recoleta, December 3, 2011.

<sup>76</sup> “Local clinics and hospitals that organized support networks for the most needed population who suffered from the lack of basic services including the prevalence of diarrhea, bronchopneumonia and infectious diseases”. Ministerio de Educación, Junta Nacional de Jardines Infantiles, *Los niños del 70 (el día en que nació la JUNJI)*, Santiago, Ediciones de la JUNJI, 2015, p. 35.

<sup>77</sup> He later took on a high position in the SNS during the Allende presidency, was exiled in Mexico during the dictatorship and when interviewed headed Unidad Patrimonio Cultural de Salud/ Unit of Health Cultural Patrimony, a center dedicated to rescuing the history of Chile’s public health system. Personal interview, Unit of Health Cultural Patrimony offices, October 14, 2011.

<sup>78</sup> *Ibid.*

resources. Renata recalls how mobilized the community became and how community members were able to successfully lobby to increase resources at their local clinic:

“[...] lots of mothers’ centers, neighborhood associations. They would organize at the clinic when they wanted ‘something more’. For example, there was a time before ’73 when there wasn’t a doctor. So everybody got together, and they took over the clinic, and obviously by the next day there were doctors. Doctors from the hospital Roberto del Rio, who were with us for many years”<sup>79</sup>.

Dr. Hevia recalls having the need for an ambulance and a community member who wanted to drive this ambulance. They managed to get a donation from the SNS of an ambulance and trained this community member to deliver babies and he became an informal emergency delivery attendant<sup>80</sup>.

In spite of the limited infrastructural conditions, the commitment to effectively make true on the promises stipulated in the 1954 PNAC during Frei’s government was such that Ruiz-Esquide remembers instances of the SNS transporting milk and medical teams to remote areas by helicopter:

“Dr. Hepp, he was a high subdirector of the SNS around 1965-66, under Eduardo Frei Montalva. He said ‘I don’t have highways, so I’ll use a helicopter.’ And he did! People would say, ‘It’s an expense’. Of course it was, but he was in charge of a province that did not have roads. So he said ‘my calculation is that it costs me 100 million pesos to take the helicopter, and I save’ according to his statistics ‘X deaths, X quantity of sick people because they don’t get preventative care or have time to make it to a hospital. So I would rather spend 100 million’”<sup>81</sup>.

The above text illustrates the way that seen from a citizen perspective, PNAC was sometimes effectively the first extension of the modern state, only later followed by roads and infrastructure.

### *Increasing the production of powdered milk*

As mentioned above, all milk distribution and coverage efforts had a counterpart in efforts to increase milk imports and production. The process of securing milk for state distribution reflects changing trends in development strategies. Between 1930 and the 1980’s, a state-led model of development and ideas of ISI were translated into efforts to create domestic industries. In spite of these initiatives, by the end of the 1940’s most of the milk distributed by the state was still imported. The 1940’s had brought on the creation of international organizations including the World Health Organization (1946) and the United Nations (1945), which facilitated Chile getting international donations for the milk program. Milk produced through the state-Nestlé consortium or pasteurized nationally was supplemented with dehydrated milk provided via UNICEF and Caritas

<sup>79</sup> Family Interview, Recoleta home, October 17, 2011.

<sup>80</sup> Personal interview, Unit of Health Cultural Patrimony offices, October 14, 2011.

<sup>81</sup> Personal interview, former Senate dependencies, December 22, 2011.



humanitarian donations, which distributed the surpluses produced in industrialized countries<sup>82</sup>. In the lines of Cepalista thinking at the time that looked to free the country from international dependencies<sup>83</sup>, in 1957 Chile negotiated with the UNICEF so that this organization would donate not only milk products but also the infrastructure and technology to produce milk. Minister of Salubrity 1959-61, Dr. Francisco Mardones Restat was instrumental in that process. Dr. Francisco Mardones Santander recalls “During those years, he invited UNICEF to donate processing plants for dehydrated milk instead of donating UNICEF milk. He said ‘why don’t you instead give us processing plants so we can produce powdered milk?’”<sup>84</sup>.

By the late 1950’s Chile had built its first two powdered milk processing plants and incentives for dairy farmers to organize into cooperatives in order to supply these with fresh milk were established<sup>85</sup>. Milk cooperatives had functioned since the 1930’s, particularly after the 1935 law that made pasteurization mandatory and led to the installation of the first state-owned milk processing plant<sup>86</sup>. Cooperatives were central in the organization of production plants and during Frei’s government, the state directly and indirectly favored the formation of cooperatives through organisms such as the Corporación de Reforma Agraria/Agrarian Reform Corporation (CORA) and the Instituto de Desarrollo Agropecuario/Institute for Agricultural and Livestock Development (INDAP)<sup>87</sup>. In addition, in conjunction with the United Nations Development Programme (UNDP), the Food and Agricultural Organization of the United Nations (FAO) and donations from developed countries, the state created a Technological Center for Milk tasked with the mission to facilitate the transfer and development of technology<sup>88</sup>.

On the whole, these efforts to up the national milk production were a success. According to the lectures of Professor Dr. Julio Santa María, between 1927 to 1955 average milk availability went from 36 annual liters in 1927 to 110.8 in 1955 per capita<sup>89</sup>. As can be seen in Table 2 the production of powdered milk also increased and between 1964 and 1970: reception of milk in plants increased by 21% and output of powdered milk increased by 55% (perhaps reflecting increased efficiency in production).

<sup>82</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, p. 41.

<sup>83</sup> For an example of this line of thought, see Fernando Henrique Cardoso and Enzo Faletto, *Dependency and development in Latin America*, Berkeley, University of California Press, 1979.

<sup>84</sup> “My father, Francisco Mardones Restat, was instrumental to this and so was an uncle of mine, Minister of Health Jorge Mardones Restat who created the National Health Service in `52. So, in those years, he brought, I mean to say he invited UNICEF. He said ‘Why don’t you instead give me dehydrating milk plants to produce powdered milk?’” Dr. Francisco Mardones Santander, professor of Public Health and Nutrition, son of Dr. Francisco Mardones Restat and nephew of Dr. Jorge Mardones Restat, remembers being a witness of the extension of the milk program as a child. Interview July 26, 2013. Personal interview, School Public Health Pontificia Universidad Católica de Chile, July 26, 2013.

<sup>85</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, pp. 52-54.

<sup>86</sup> Nicolás Carmona, *La Central de Leche ‘Chile’. Un caso de industrialización estatal fallido (1935-1960)*, seminario para optar al grado de Licenciado en Historia, Santiago, Universidad de Chile, 2008.

<sup>87</sup> Ministerio de Economía, Fomento y Turismo, *El cooperativismo en Chile*, Unidad de Estudios, julio 2014, disponible en [www.economia.gob.cl/2014/07/21/el-cooperativismo-en-chile.htm](http://www.economia.gob.cl/2014/07/21/el-cooperativismo-en-chile.htm). [Fecha de consulta: Febrero 2016].

<sup>88</sup> Gobierno de Chile, *Nutrición para el desarrollo...*, *op. cit.*, p. 54.

<sup>89</sup> Aguilera y Zúñiga, *op. cit.*, p. 56.

TABLE 2  
*National Milk Production, Reception in Plants,  
 Powdered Milk Production and Price of Milk Sold to Plants (in millions of liters),  
 1957-1968*

Year	National Production <sup>90</sup>	Reception in Plants	Powdered Milk Production (kg.)	Milk Sold to Plants (\$/1.000 lts <sup>91</sup> )
1957	709.5	249.7	–	–
1958	733.6	312.7	9,003,511	–
1959	731.1	357.2	11,833,498	–
1960	760.4	355.2	12,552,758	–
1961	775.1	376.1	13,654,957	–
1962	739.2	370.1	14,467,795	–
1963	796.3	425.6	16,992,506	–
1964	830.5	435	18,189,791	–
1965	810.2	415.8	18,592,765	63.53
1966	829.8	415.1	18,974,272	78.98
1967	847	439.2	20,623,341	87.19
1968	911	476.4	24,260,468	88.58
1969	982	519.4	26,869,392	91.27
1970	895.1	525.9	28,135,201	89.54
1971	940	571.2	32,836,654	96.77
1972	880	506.3	27,262,979	78.3
1973	855	441.7	28,788,198	129.4
1974	905.8	522.8	31,314,275	134.57

Sources: Oficina de Planificación Agrícola y Servicio Agrícola Ganadero (ODEPA), “Leche: producción y elaboración de productos lácteos”, en *Publicación N° 3*, Santiago, Ministerio de Agricultura, 1970; Departamento de Economía Agraria, *Boletín Agro Estadístico N° 21*, Santiago, Ministerio de Agricultura, (ODEPA), 1975?; Departamento de Economía Agraria, *Chile: Estadísticas Agropecuarias 1965-1974*, Ministerio de Agricultura (ODEPA), 1976, pp. 87-88.

The government assessed the process as a success and in a 1970 document highlighted both the incorporation of technology and the alliances with dairy producers:

“This product [powdered milk] is one of those that has had the greatest benefits with the implementation of new techniques and modern equipment, specialized in this type of elaboration. [...] A fact worth highlighting is the interest shown by the industry in its eagerness to be

<sup>90</sup> Estimates based on reception in plants and 1965 Agricultural Census.

<sup>91</sup> Indexed to 1974 values (\$134,57 per thousand liters).

constantly renewed... This has allowed, in the country today, the consumption of a foodstuff of high sanitary and nutritional quality [...] and from 1961 on, production of powdered milk significantly increased”<sup>92</sup>.

The construction of clinics and increased availability of milk did not automatically translate into the extension of services. The process required door-to-door recruitment of recipients convincing mothers both of the benefits of children consuming powdered milk and of adhering to a preventive healthcare program. In the next section, I attempt to reconstruct what this process of extension looked like from the ground level based on testimonies from providers and recipients at two Santiago neighborhood clinics.

REACHING OUT TO MOTHERS:  
BUILDING THE CHILEAN SOCIAL STATE ONE INTERACTION AT A TIME,  
1964-1970

The implementation of the PNAC in the 1960’s can serve as a lens to view the actual extension of the modern state towards families. On the ground level this extension happened in a context of increased political activism and outreach in which neighborhood clinic workers would go door-to-door recruiting beneficiaries. For many women –neither habitual voters nor formally employed- these home visits constituted their first contact with the state. These face-to-face encounters forged in the intimacy of the domestic sphere, were gradually migrated to neighborhood clinics and are key to creating a sense that milk and maternal-infant healthcare are universal entitlements. This section explores the extension of the milk program in the late 1960’s. It reconstructs the ground-level mechanisms that were the seed of families’ adherence to the milk program. In order to understand this process, it is necessary to first examine the general context of this time period from the viewpoint of women.

By the 1964 elections, voting had become mandatory and registration of female voters increased from 35% to 70% meaning that for the first time, candidates were pushed to appeal to the women voters directly, who were therefore at the heart of the political campaign<sup>93</sup>. Both Frei and Allende held conservative views of women-as-mothers<sup>94</sup>. The Christian Democrat candidate was particularly successful at catering his campaign towards women, creating ground-level centros de madres/ mothers’ centers through which to recruit voters, promising a sewing machine for every woman<sup>95</sup>, formally committing

---

<sup>92</sup> Oficina de Planificación Agrícola / Servicio Agrícola y Ganadero SAG, *LECHE, Producción y elaboración de productos lácteos, INDICADORES AGROECONÓMICOS, Publicación N° 3*, Santiago, Ministerio de Agricultura, 1970, pp. 50-51.

<sup>93</sup> Women and men voted in separate locations and results were tallied by location providing precise accounting of women and men’s votes, Mooney, *op. cit.*, 75.

<sup>94</sup> Salvador Allende was not successful at appealing directly to women and class cleavages took precedent over gender interests in his campaign.

<sup>95</sup> Sewing machines represent modernity and technology, in particular one that is appropriate for women. With these women could make clothes for their family or produce products for sale increasing their income without leaving the home. For more on this, see Power, *op. cit.*

to support family planning and using the scare campaign to reinforce notions that an eventual socialist government would be particularly harmful for women<sup>96</sup>.

The Promoción Popular program required the creation of base organizations such as neighbors' associations (*juntas de vecinos*), sport clubs, and mothers' centers, which were deeply tied to local government offices such as municipalities and neighborhood clinics. For example, using these as headquarters for meetings, government workers would provide workshops with information and materials for these associations to then promulgate and associations would channel their demands on the public sector through these local institutions. Once Frei was in office and the *promoción popular* began implementation, the aforementioned mothers' centers proved an important space of participation. By the end of the administration in 1970, the number of existing organizations had reached 9,000 across the country, with 450,000 women participating in them<sup>97</sup>. Additionally, this was the first government to create a state office specially mandated to address women's issues, with the *Oficina Nacional de la Mujer*, created in 1969<sup>98</sup>. Mooney stresses that while both the election campaign and mothers' centers aimed at "disciplining women, especially the poor", they also achieved an unprecedented rate of female participation<sup>99</sup> and feminist scholars have examined mothers centers' in terms of their potential as sites for emancipation (as well as their role in reinforcing traditional roles for women)<sup>100</sup>.

Nonetheless, despite the aforementioned changes, many women remained reluctant to use public services. Zárate and Godoy identify the SNS measures that contributed and limited the increase of clinic visits, in particular related to pre-natal control. Barriers included what they describe as a lack of interest and even fear on behalf of women in attending these prenatal check-ups<sup>101</sup>. Therefore, families did not come to clinics for preventative check-ups spontaneously and recruiting milk recipients involved establishing relationships with mothers in their homes on a one-to-one basis. The clinic workers interviewed for this project recall encountering some resistance in these home visits, explaining that many people at the time preferred traditional healers or were uncomfortable receiving a stranger in their houses given the precarious conditions in which they lived. In the words of Renata, Recoleta paramedic at the time: "There were people who

---

<sup>96</sup> According to Power, the US-backed scare campaign also contributed to Allende's low popularity amongst women. Power, *op. cit.*

<sup>97</sup> Jacqueline Saintard, "La visión de la mujer en el pensamiento y acción del Presidente Eduardo Frei Montalva", en Biblioteca del Congreso Nacional, *Eduardo Frei Montalva: Fe, política y cambio social*, Santiago, Ediciones Biblioteca del Congreso Nacional, 2013, p. 280.

<sup>98</sup> *Op. cit.*, pp. 285-286.

<sup>99</sup> Mooney, *op. cit.*, pp. 77-78.

<sup>100</sup> For discussion on this tension between reinforcing conservative values and potential for emancipation in mothers groups, see: Power, *op. cit.*; Valdés and Weinstein, *op. cit.*; Teresa Valdés, Marisa Weinstein, María Isabel Toledo, y Lilian Letelier, "Centros de madres, 1973-1989: solo disciplinamiento?", en *Documento de Trabajo*, N° 416, Santiago, FLACSO-Chile, 1989.

<sup>101</sup> These included the creation of health clinics close to the residences of mothers, the priority placed on pediatric-obstetric services and the creation of services for premature infants. Challenges included the difficulty of extending these services to rural areas, the difficulty in securing medical professionals at rural posts and what they describes as a lack of interest and even fear on behalf of women in attending these prenatal check-ups. Zárate y Godoy, *op. cit.*, p. 147.

would not agree to let us in, because they lived in poverty: houses with no floor, got water from a well [...]"<sup>102</sup>.

Recruiting PNAC beneficiaries in this context was a laborious process and neighborhood clinic workers combed through working class neighborhoods establishing relationships with mothers of infants on a one-to-one basis. This outreach was considered a fundamental part of their duties. Patricia, a paramedic at the same Recoleta clinic from 1967-2010 explains that clinic workers organized their time as having a half a day "in the field" and half the day in the clinic. Everybody [the technicians] took turns in this way<sup>103</sup>. In the eyes of clinic workers, the modern childrearing techniques they would teach were not only intimately tied to Frei's popular advancement project and national development, but were also potentially life saving. Renata emphatically explained: "It was very important to transmit the education. People could not remain ignorant about the issues we were addressing"<sup>104</sup>.

Home visits were not only to perform check-ups but also had the mission of persuasion (on the positive benefits of clinic services). A 1972 Ministry of Health manual, which prepares health volunteers for home visits, illustrates this explicit state-led mission of changing people's minds and practices by creating a relationship with a person (in which the volunteer becomes the representative of the state and spokeswoman for so-called modern childrearing techniques and nutritional guidelines). In this document, the first step is referred to as "capturing the trust of the family nucleus in order for them to modify erroneous ideas they hold about milk" in order to then convince them to really value the PNAC program and introduce habits of proper and new forms of milk consumption<sup>105</sup>.

In these visits, clinic workers were careful to use appropriate manners and present information in a way that was cogent to visited families: "It was not just arriving and entering, we had to greet the family, identify ourselves with our name. I would wear a white badge with my name and title". Renata recounts how she would explain SNS measures: "[...] and in their language: poor people, with no education, also peasants"<sup>106</sup>. Unlike mediations from charitable women in previous initiatives, which tended to be encounters between elite women and the poor, clinic workers—especially paramedics, auxiliaries, and medical technicians—tended to be from the same neighborhood as those women they serviced. This changed the dynamics of these encounters, creating a different kind of relationship, less vertical and one that encouraged joint projects. For example, both Patricia and Renata live close to the Recoleta clinic in which they worked for over forty years. Referring to the way this closeness helps bolster trust, Renata explains: "furthermore, they were like neighbors in that they knew me from when I was a little girl"<sup>107</sup>.

<sup>102</sup> Personal interview, Recoleta, October 17, 2011.

<sup>103</sup> Personal interview, Recoleta, October 18, 2011.

<sup>104</sup> Personal interview, Recoleta, October 17, 2011.

<sup>105</sup> Servicio Nacional de Salud, *Instructivo para personas que participan en labores educativas, Programa Nacional de Leche*, Santiago, Ministerio de Salud, 1972, p. 22.

<sup>106</sup> Personal interview, Recoleta, October 17, 2011.

<sup>107</sup> *Ibid.*

Home visits were not a one-time occurrence, did not have strict time limits, nor were the contents of interactions during these narrowly bound<sup>108</sup>. In these encounters, health-care workers would provide education on modern childrearing techniques, creating sanitary conditions within the home. These home visits focused mostly on education, providing knowledge to create sanitary conditions for the family:

“The main thing in that time was what we called ‘on-the-ground attention’, education. We would go to the houses of clinic beneficiaries and we would examine everybody, from the newborn to the grandfather. We did a lot of education. We would teach them to make bottles, to bathe babies, change them, prepare foods, etc. [...]”<sup>109</sup>.

Patricia, who spent most of her forty-four years at the clinic performing the preventative healthcare checks that were part of the PNAC program explains that they did everything related to mothers and children: made reports, did all the paperwork for women to get paid for their post-natal benefits, taught mothers how to make bottles: “I would go to sit in houses to observe how they prepared bottles, if the technique was correct, how much they put in, how they did it”<sup>110</sup>. Clinic workers used creative strategies to provide real solutions to the needs in the community,

“[...] we had to do everything – from visiting a lady who had nothing to eat, bringing cardboard boxes to her so she could line her precarious home against the rain, collecting money to buy her groceries; drops, vaccines, bronco-pneumonia campaigns. We would go out at night in a truck that we would borrow, like the one *Padre Hurtado* had [...] because quality of life was extremely bad, people did not have the minimal conditions”<sup>111</sup>.

She describes her role as extremely proactive and the tasks she performed as varied: “We wouldn’t wait for the mother to go to the clinic. If something needed to be done, we would just do it while we were out”.

There was space for recipients to talk about their own concerns in these encounters. Clinic workers would see their job as trying to gently steer the conversation in order to cover those points they considered key.

“I might go to the same house every day, and they would not close the door on me. [...] I would arrive at the time they would be preparing the bottle. [...] Sometimes we would be inside for an hour, because empathy was formed between us, we would talk about other things. But we would *try* to always cover those specific objectives for which the doctor or nurse had solicited the visit: that the child was not gaining weight, was arriving dirty for medical visits, etc. [...]”<sup>112</sup>.

---

<sup>108</sup> This is very different to today’s context where interactions are governed by strict guidelines, program target goals and time constraints.

<sup>109</sup> *Ibid.*

<sup>110</sup> Personal interview, Recoleta, October 18, 2011.

<sup>111</sup> *Ibid.*

<sup>112</sup> Personal interview, Recoleta, October 17, 2011.

In her analysis of *visitadoras sociales*/social visitors, Illanes found that women put social workers to the test by placing their own demands on the table and pressuring them to address and provide solutions to these, creating what she calls “negotiated conditionality”<sup>113</sup>. My analysis leads me to a similar conclusion and in spite of the fact that the relationship was structured vertically, working class women were not completely passive in these interactions and expressed concerns outside of program guidelines.

The families I interviewed recollect these home visits with affection and their fond narratives echo those of clinic workers, stating that home visits occurred multiple times, visitors were courteous and the information imparted in these encounters useful. For example, Maria Fuentes recounts:

“They would teach us to change the child, how to feed him, that kinds of things; and about cleanliness [...]. They would look at everything. I remember I had my infant there [pointing to other room] and they would look at him and say “everything is good” [...].”<sup>114</sup>.

The oldest members of the Sura family, long-time Macul residents, remember their home visits: “They would visit me when my children were newborns. They would check the babies one by one. And for my youngest one, they would visit him once a month and bring him a special milk”<sup>115</sup>.

It should be noted that the dynamics I have described above are relevant mostly for urban areas. Primary healthcare extension also occurred in the countryside during Frei’s government by sending doctors to rural areas that had never had access to modern healthcare<sup>116</sup>. Given the distances between houses door-to-door recruitment was less feasible and other mechanisms of recruitment were employed. These included songs taught in schools encouraging families to attend local or monthly ambulant clinics, vaccine or educational campaigns accompanied with a community barbeque<sup>117</sup>. One of my interviewees recalls the hard work of traveling by train with a group of midwives, nurses, and paramedics to different rural areas setting up an ambulatory clinic in a church or school to administrate vaccines, perform check-ups, and distribute milk.

One of the main tasks of home visits was to convince mothers to bring their infants to the clinic for the medical check-ups and milk and how they attempted for the warm and empathetic quality of home visits to follow this migration from home visits to a public site. Renata explains:

“So you had to create empathy with people, because that empathy was part of the services delivered at the clinic. That was the most important thing. The fact of receiving a person in the center means that you get to know the person, the person begins to trust you, that was the idea”<sup>118</sup>.

---

<sup>113</sup> Illanes, *Cuerpo y sangre...*, *op. cit.*, pp. 306-307.

<sup>114</sup> Personal interview, Recoleta, December 1, 2011.

<sup>115</sup> Family interview, December 15, 2011.

<sup>116</sup> Junta Nacional de Jardines Infantiles, *op. cit.*, p. 35.

<sup>117</sup> Conversation with historian Manuel Gárate, son of a rural public health pediatrician, Universidad Diego Portales, Santiago, June 27, 2013.

<sup>118</sup> Personal interview, Recoleta, October 17, 2011.

Family narratives also reflect this transition and while interviewees recount older kids receiving services at home, they attended the clinic for later offspring. Maria remembers “Later, when the child was older I would bring him there [to the local clinic] for check-ups and that was also good”<sup>119</sup>. This quote provides illustrations on how these home visits were gradually migrated from homes to local clinics. Within a few years, PNAC users were not only acquiescing to home visits, but also regularly visiting the clinic.

The increased attendance to the clinic is therefore a result of the success of the efforts at door-to-door recruitment of mothers. While many urban poor, peasants, and women previously had little contact with the state; the effective extension of public services into neighborhoods created new linkages and previously marginalized groups begin to self identify as citizens; and as such make demands on local services and the state<sup>120</sup>.

Another important task of home visits was to help citizens conceptualize powdered milk as a valuable resource. Creating acceptance of powdered milk also occurred in laborious one-on-one encounters. It was met with suspicions ranging from it being considered chalk to a CIA product to stupefy the developing world. It is sustained in this article that the personalized mediated person-to-person efforts at creating acceptance contributed to the success of this program<sup>121</sup>. Graciela Gonzalez, nutritionist in the public health service starting in 1953, remembers the first UN and UNICEF dehydrated milk donations as a disaster “because people didn’t know. They would say, what is this? Flour?” and explains that “If people did not know how to prepare the milk, they would end up with something frightful”.

“People didn’t understand that a natural [liquid] milk was dehydrated and would become reduced to this product [...]. They would say “cows produce milk, how can this be milk? [...] So we had to begin by explaining the process. How the milk was dehydrated to make this product which was so strange for them – which was powder”<sup>122</sup>.

She recounts the different strategies she and her colleagues tried to get people to trust and consume this strange item: “The simplest way to do this was to make a drawing to present to people: here the milk comes out of the cow, we put the milk in this machine and out comes powder. We would invent things”<sup>123</sup>.

---

<sup>119</sup> Personal interview, Recoleta, December 1, 2011.

<sup>120</sup> The increased demands also reflect the increased mobilization of the time: a combination of the popular promotion programs of the Christian Democrats, the increased social effervescence and polarizing cold war context. Still other Chileans remember this first contact as occurring during the Allende years. One shantytown dweller recalls “We never had shoes before Allende was elected, we never went to school before Allende was elected”. See Judy Maloof, *Voices of Resistance: Testimonies of Cuban and Chilean Women*, Lexington, University of Kentucky Press, 1999, p. 152.

<sup>121</sup> This lack of acceptance is not trivial and milk programs in other countries failed precisely because they were unable to create acceptance of distributed milks. For example, see case of Incaparina in Guatemala. Interview with Dr. Fernando Mönckeberg Barros, CONIN offices in Santiago, November 17, 2011; Conversations with policy experts at InterAmerican Foundation for Grassroots Development Mid-year Conference, Antigua, Guatemala, February 2013.

<sup>122</sup> Personal interview, Santiago, December 27, 2011.

<sup>123</sup> *Ibid.*



For example, in Lota, a poor coal mining town which had high infant nutrition and mortality rates, they would stage demonstrations on how to prepare the milk and then invite local clinic doctors to come on stage to try it<sup>124</sup>. These demonstrations were also performed in different cities, often staged in local movie theatres<sup>125</sup>. For Graciela, the process of creating acceptance was complete when teachers, families and mothers began to demand more milk and make complaints that distributed milk quantities were insufficient, “Done” she laughingly remembers “here we won, we’re OK here”<sup>126</sup>. Towards the end of the period analyzed in this article, state efforts were still concerned with creating acceptability for powdered milk. A 1972 PNAC instructive shows that this process was not completed in the time period analyzed in this article, providing detailed instructions on how to demonstrate rehydration techniques, convincing people that powdered milk was in fact milk and dismissing what are referred to as erroneous beliefs on powdered milk<sup>127</sup>.

#### CONCLUSION

Initiatives that combined milk distribution and preventative healthcare programs for infants gained traction in the early 20<sup>th</sup> century, evolving from isolated charitable initiatives to the full blown installation of a free and universal state-led program. In order to secure supplies for milk programs, the state also had to encourage the development and industrialization of the dairy sector. In the second part of the century, the expansion of these services occurred in tandem with the effective infrastructural and bureaucratic extension of the state, making milk programs often the first social programs to regularly reach female citizens. Therefore, from a citizen perspective, the implementation of the PNAC is closely linked to the extension of the modern state.

While there were obstacles to home visits by clinic workers, within a few years, mothers were not only acquiescing to them, but also regularly visiting their local clinics and negotiating benefits in encounters with health workers. The face-to-face encounters, forged in the intimacy of the domestic sphere and later transported to a public space, are key to creating a sense of entitlement to these benefits. This idea of state-sponsored milk as an inalienable right became further consolidated during Chile’s brief socialist experiment (1971-1973). President Allende’s ambitious Medio Litro/ Half Liter milk program was at the center of his social platform and his government almost bankrupted itself in order to make true on the campaign promise of delivering a daily ration of a half-liter

---

<sup>124</sup> According to her, this experience mimicked a similar one in England where Queen Elizabeth tried to promote the consumption of mackerel by publicly eating it herself. Based on this, she and her colleague decided to “do as the queen.” Recruiting local authorities to visibly drink the milk was important given that other authorities –teachers– were resisting milk programs stating “that the Yankees want to make us eat anything and what have you”. Personal interview, Santiago, December 27, 2011.

<sup>125</sup> *Ibid*

<sup>126</sup> *Ibid*.

<sup>127</sup> Servicio Nacional de Salud, *op. cit.*, pp. 9, 11-13, 22.

of milk for every child<sup>128</sup>. Receiving those services offered and presenting demands for additional services represents a process of families taking ownership of neighborhood clinics, beginning to feel these are sites that are theirs by-right; and furthermore, wanting to participate in the definition of these rights. From here on, public milk distribution will be understood as an acquired right and attempts to cut these programs immediately resisted by grass-roots efforts. Thus, the unique process of recruitment, had implications for the eventual path-dependent trajectory of Chilean milk-for-care program<sup>129</sup>.

---

<sup>128</sup> Allende's signature social program Medio Litro/ Half Liter committed to distribute a half-liter of powdered milk p/day to all children under the age of 15 and was layered alongside the PNAC. For more on Medio Litro see: Luis Corvalán, *op. cit.*, pp. 25-31, 159, 297; Jael Goldsmith Weil, *Striving for Services: Citizen-State Relations in Chile's Changing Economic, Political and Welfare Regimes, 1954-2010*, Ph.D., Political Science, Northwestern University, 2014, pp. 101-106.

<sup>129</sup> Goldsmith, *Striving for Services... op. cit.*; Jael Goldsmith Weil "Using Critical Junctures to Explain Continuity: The Case of State Milk in Neoliberal Chile", in *Bulletin of Latin American Research*, vol. 36, N° 1, London, 2017.