An overview of early childhood development services in Montenegro

Summary Report

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1. INTRODUCTION

Early childhood, the period from conception to compulsory primary-school age, is the most critical developmental stage in a child's life. Research has shown that during the first 1,000 days of life, starting from conception, some 700 neuronal connections are created in a child's brain every second, with 90% of the synapses already formed by the age of 5. To allow the brain to grow and the child to develop to their full potential, children need nurturing care that responds to their holistic needs. The experiences during pregnancy and in the first years of a child's life have far-reaching consequences for their further physical, cognitive and socio-emotional development. Decades of child development research and evidence from studies on deprivation, resilience, early intervention, and early brain development clearly show that the early years of life are a cost-effective entry point for improving lifelong wellbeing and productivity.[1]

Young children who receive adequate and loving attention and care during their critical early years are more likely to lead healthy and productive lives, achieve their potentials and contribute to the development of society and the well-being of future generations. Children who fall behind in these early years often never catch up with their peers, perpetuating a cycle of underachievement and high dropout rates that continues to determine them throughout their lives.[2]

1.1. Global commitment to ECD

The recognition of the importance of this stage in life for the potentials of individuals and societies to be realized puts early childhood development (ECD) at the centre of the global development agenda. ECD is not only a human right but also a tool for attaining the full set of Sustainable Development Goals (SDGs).[3] Global institutions, such as UNICEF, the World Health Organization (WHO) and the World Bank, have established ECD as one of their priorities, which has led to its recognition in this century as the most significant international development goal. In 2018, global partners adopted what is known as the Nurturing Care Framework (NCF), with the vision of creating a world in which every child can develop their full potential and no child is left behind.[4]

During the same year, the Framework was supported by the G20 and included in its Initiative for ECD, which was a revolutionary moment – the first time the G20 had addressed the issue and a move that could help to break the global cycle of poverty and inequality, especially for the most vulnerable children. The sector has also been recognized by the EU and included in their ECD initiatives, as well as those directed to reducing poverty and fostering social inclusion. The latest promising global development is an innovative dialogue to reflect on common actions and reinforce collaboration on the Global Partnership Strategy for ECD launched by UNESCO in November 2020.[5] Despite these global commitments, children's early learning and development is too often neglected, putting millions of children at a disadvantage before they even start school. The sector needs to mobilize adequate financial resources for its expansion, particularly for the most marginalized, which is a major challenge, especially in low- and lower-middle-income countries, where it attracts less policy attention. Furthermore, less than 1% of international aid for education supports this sector,[6] and there is a need for improved efficiency and transparency in resource allocation and utilization.[7]

1.2. Why does a nurturing environment matter for young children?

Under the globally accepted NCF, the most supportive environment is one that provides nurturing care for the child – conditions that promote good health, adequate nutrition, opportunities for early learning, responsive caregiving, and security and safety. Children need all five domains of the NCF to reach their full potentials as every aspect of their development is interrelated, interdependent and mutually reinforcing. Nurturing care puts children at its focus, but also parents and caregivers, as those who are responsible for creating an environment in which children can develop and thrive.[8]

ECD policies need to ensure that:

- **All children, particularly vulnerable ones, have the same access to the quality health care, nutrition, protection and early learning needed to respond to their developmental needs;**
- **Parents and caregivers receive support in providing nurturing care to their children.**

The NCF defines services and programmes that children and caregivers need under each domain of the family-centred approach to support their optimal development:

1. Health: immunization, disease prevention and treatment, safe water, improved sanitation and good hygiene, and the mental health of caregivers.

2. Nutrition: an adequate diet that meets nutrient needs for optimal growth and development, including the nutritional status of the mother during pregnancy, early initiation and continuation of exclusive breastfeeding, and dietary diversity.

3. Early learning: access to preschool and other early learning opportunities.

4. Responsive caregiving: engagement with a parent or caregiver that includes responsive care and provision of a safe and nurturing environment.

5. Protection: from violence, abuse, neglect, the accumulated effects of poverty, environmental hazards, and prolonged exposure to other adversities.

Figure 1: Nurturing care domains conducive to children reaching their full potential[9]

The NCF is intended to inspire a wide range of stakeholders, predominantly decision-makers, service providers, and the bodies responsible for implementation of the programme to plan and take coordinated actions to strengthen the ECD sector. It calls for a whole-of-society approach, and government leadership in mobilizing multi-level actions represented by the ecological framework, that encompasses policies, services, empowered communities and family capabilities. The framework guides countries to design and adopt multi-sector policies focusing on young children, and lays out three levels of support, depending on caregivers' and children's needs, which are described as: *universal support* for everyone, provided through the services that families use most; *targeted support aimed* at families who are affected by risks and need support to improve their capacity to cope; and *indicated support* that provides extra services to families or children with greater needs.[10] The NCF adopts a lifecycle approach where investments in the early years must be complemented by investments throughout schooling and adolescence.

1.3. Background on Montenegro

Montenegro is an upper-middle-income country situated in South-East Europe, which is aspiring to join the EU. According to the 2011 census, the total population of Montenegro was 620,029: 306,236 men (49.4%) and 313,793 women (50.6%). According to MONSTAT's 2015 data, the proportion of children under the age of 6 in the population was 8.5%. Based on UN data from 2018, the Human Development Index (HDI) for Montenegro stood at 0.814,[11] which positions Montenegro among countries with a high HDI.[12] However, according to World Bank data on the Human Capital Index (HCI),[13] a child born in 2018 in Montenegro will realize only 62% of their full potential by the age of 18, compared to children born in countries with better education and health systems. On average, children can expect to complete 12.4 years of schooling by the age of 18, which is equivalent to 8.6 years of effective education, taking into account the quality of learning (World Bank, 2018).[14] **The findings of the PISA 2018 study[15] show that students in Montenegro underperform compared to their peers in other countries in reading, mathematics and science, leading to a difference between Montenegrin students and the best-performing ones of close to two academic years. The results suggest that 15-year-olds who attended preschool for over a year were, on average, outperforming on the PISA test in reading literacy.**

The state has signed and ratified several United Nations conventions that directly or indirectly refer to children, among which are: the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD). In 2016, Montenegro adopted the *National Sustainable Development Strategy (NSDS)* by 2030, which translates the UN Agenda for Sustainable Development into the national context.

1.4. Who is this sector analysis for?

The NCF is an essential part of the SDGs agenda embraced by Montenegro. Given that Montenegro does not have a multi-sector ECD strategy, the present analysis aims to map the existing provision and, to a certain extent, identify gaps through the lenses offered by the NCF as the conceptual framework for the Study. The Study identifies important national policies and regulations in relevant sectors and provides an assessment of the status of existing ECD system components in the five domains relevant for nurturing care, concerning the period from conception until the age of 6. It builds on the latest research findings and global guidance, and reflects the views of key respondents obtained through a series of interviews. The Study scans several contextual factors known to impact ECD service access, quality, equity and delivery, including differences across socio-economic status, and issues relevant to the workforce. It examines a context for the development of the ECD Strategy in Montenegro and provides recommendations for the next steps. It is intended to support policymakers and legislators, programme managers and technical staff in the health, education, child protection, and welfare sectors, funders and development partners, to take action to help young children survive and thrive.

1.5. Methodology

The Study aims to provide evidence on the status of ECD in Montenegro by mapping existing interventions and programmes, to guide services and policy landscape for possible improvements. The analysis was conducted in 2019, and it included desk and field research and working with a Reference Group set up to support the research. The *desk research* provided analysis of close to 70 laws, strategies, studies and surveys needed for understanding the ECD sector and its legal bases. It also examined materials produced by UNICEF, the World Bank and the WHO. The *field research* generated information from 24 purposefully targeted respondents through semi-structured interviews, who represented decision-makers, civil society organizations and practitioners working directly with children and parents. The respondents were selected based on their knowledge of, and involvement in, designing policies and laws related to support to children and parents, and the knowledge of and involvement in the delivery of services intended for parents, particularly those aimed at vulnerable groups. UNICEF initiated the high-level *Reference Group* for ECD to guide the Study, represented by all the relevant ministries, public institutions and civil society. The Group provided feedback on the concept and the methodological framework during the inception stage and discussed the main research findings at the later stage.

Interpretation of the findings should take into consideration the inherent limitations of the design, sample size and sample representation, and limited timeframe. It should be noted that information and evidence of service quality were missing for some of the mapped services. The mapping exercise was limited to the programmes offered and financed by the government.

Given the extensive scope of the analysis, parents were not directly involved in the research. However, NGOs representing parents gave certain insights into the views of parents, and service beneficiaries, and findings relevant to parents' perceptions were also sourced from other surveys.

The original study was updated to reflect new developments in ECD, and the immediate impact of the COVID-19 pandemic, to the extent possible, on children, families and services, and possible long-term implications for maintaining and improving holistic support to young children.

2. OVERVIEW

Montenegro has a total population of 620,029 (MONSTAT, 2011), while children under 6 account for 8.5% of the total population (MONSTAT, 2011). It ranks among upper-middle-income countries.	Montenegro is a member of the United Nations (2006), the Council of Europe (2007) and NATO (2017), and a candidate country for EU accession (2010	Montenegro is a signatory to the UN Convention on the Rights of the Child. The National Sustainable Development Strategy to 2030 was adopted in 2016 as an umbrella, horizontal, long-term strategy.	The 2019–2023 Strategy for the Realization of Children's Rights has been adopted. The Council for the Rights of the Child has been operational since 2009, as an inter-agency coordination body, under the coordination of the deputy prime minister since 2021.	Montenegro does not have an inter-sector strategy on early childhood development.

The infant mortality rate is **2‰** Timely coverage with the MMR1 vaccine 23.8%, coverage with the DTP3 vaccine is 84.17% (JRF 2020) Early childbearing, i.e. the percentage of women aged 20–24 who have had a live birth before the age of 18, is 2.8%, while this percentage is much higher for Roma women – 36.2% (MICS 2018)	At the population level, 24.1% of newborns are breastfed during the first hour after birth, while the share is higher for the Roma population and amounts to 40.9% (MICS 2018) 20% of children are exclusively breastfeed during their first six months, and for the Roma population this share stands at 14% (MICS, 2018) 7.2% of children from the total population and 20.8% of the Roma children under 5 years of age are moderately or severely stunted (MICS, 2018)	Preschool enrolment of children aged 3–6 in 2018 was 72.6% (the Ministry of Education, 2019) 15% of Roma children aged 3–6 attended preschool in 2018 (MICS, 2018) 58.1% of the general population, and 5.5% of Roma children aged under 5 have three or more children's books (MICS, 2018)	91% of children from the general population and 50.7% of Roma children aged 2–6 years were engaged in four or more activities with caregivers that foster learning (MICS, 2018) Fathers are engaged in 3.1 activities per day with their children, on average, while mothers are engaged in 4.9 activities per day with their children on average (MICS; 2018)	The birth registration rate for children under 5 years of age stands at 99%, and 96.2% for Roma (MICS, 2018) In 2018, 65.8% of children aged 1–14 were exposed to physical and/or psychological aggression from an adult member in their household. For the Roma population, the percentage is similar – 64.4% (MICS, 2018) In 2017, the relative child poverty amounted to 31.7% (SILC; 2018)

1. The **good health** domain refers to children's health, but also to the physical and mental health of the parents and caregivers who are primarily responsible for their health.	2. The **adequate nutrition** domain refers to the nutrition of mothers during pregnancy, breastfeeding and subsequent nutrition of children.	3. The **early learning** domain refers not only to preschool learning, but also to parent and caregiver motivation to enable children to learn through mutual interaction.	4. The **responsive caregiving** domain refers to the relationship of parents and caregivers towards children, i.e. their capacity to recognize their children's needs and respond to them adequately.	5. The **safety and security** domain of nurturing care includes creating conditions in which children feel safe and secure through interventions aimed at preventing violence, reducing poverty and providing care.

3. GOOD HEALTH

Sustainable Development Goal 3 calls on all states to ensure healthy lives and promote wellbeing at all ages by eliminating mortality and addressing challenges, such as non-communicable diseases or ensuring universal healthcare. The Global Strategy for Women's, Children's and Adolescents' Health until 2030, developed under the multi-stakeholder Every Women Every Child movement, supports the SDG agenda and calls on governments to increase financing and improve commitments for actions that support women's and children's health.[16]

For good health, *newborns and young children need* caregivers to: respond affectionately and well to their daily needs; minimize infections; protect them from danger; use health services and give them the right treatment when they are ill; monitor how they are, physically and emotionally; and make sure they get enough activity and sleep.[17] The NCF also supports the health and wellbeing of caregivers because there is convincing evidence that caregivers' health can affect their ability to care for a child. One essential strategy to protect children's health and development is the care their parents get before they conceive, which improves their mental health and reduces the chances of their children being born prematurely, with a low birth weight, and/or with birth-related conditions that could affect optimal development.

The Montenegrin health sector is ideally positioned to enhance child wellbeing, because almost all pregnant women and young families have regular contact with the health system through prenatal, perinatal and postnatal services, both in health centres and through home-visiting services. Under the *Health Protection Law*,[18] all children are entitled to healthcare free of charge. However, there are persisting gaps in access and coverage among Roma and Egyptian communities.[19] The health data collected in 2016 suggests that life expectancy at birth is 76.8 years, which is slightly below the European average of 77.5 years.[20] The *Strategy for Social Inclusion of Roma and Egyptians* (2016–2020) sets the estimated life expectancy for members of the Roma population at 55 years of age, which is 20 years lower on average than for a non-Roma born in the same country.[21] Montenegro ranks among the countries with the lowest infant and neonatal mortality rates, which stand at 2% and 1.3% respectively.[22] The *Health Master Plan*, adopted in 2015, which ended in 2020, identified priority areas for health safeguarding and improvements by 2020, including prevention and control of chronic, non-communicable and infectious diseases, health protection for vulnerable and disadvantaged groups and strengthening public health.

3.1. Prenatal services

The teen pregnancy rate in Montenegro is relatively low, with the country average at 2.8%.[23] However, it is worrying that teen pregnancies are quite common among the Roma and Egyptian communities, with 36% of women aged 20–24 having a live birth before the age of 18. The MICS 2018 data indicates high national coverage by prenatal services. The coverage is lower in Roma communities, which is particularly problematic in the context of early pregnancies. Birth weight is a good indicator of the health and nutritional status of the mother, and of the survival, growth, and long-term health and psycho-social development of the child. MICS 2018 found approximately 5.3% of children with a low birth weight of below 2,500 grams. This occurrence is more present in mothers with only primary education and among those in the bottom quintile, which calls for strategies by local services to facilitate improved access to prenatal care of vulnerable pregnant women. Prenatal examinations by chosen gynaecologists are governed by the PHC Rulebook[24] which stipulates the scope of preventive services for women, delivered at 18 PHCs. According to the Health Insurance Fund data, the number of preventive gynaecologist services provided is causing excessive workloads in some municipalities.

All reproductive health counselling services are expected to provide education for pregnant women that focuses on delivery, breastfeeding and the immediate postpartum period. **The Study found a lack of systemic data collection that would enable the evaluation of equitable access to health counselling by pregnant Roma women, rural women or women from other vulnerable groups and insights into service quality and its impact on mother's and children's health.**

3.2. Perinatal care

All pregnant women are entitled to delivery and post-partum care free of charge. According to MICS 2018 data, nearly all (98.6%) women aged 15–49 in the general population and the vast majority (96.6%) of Roma women gave birth in healthcare institutions. **However, it is worrying that the share of newborns who had skin-to-skin contact with their mothers, in the two years before the research, was very low and stood at 33.9% for the general population and 29.1% for Roma mothers.[25]**

The baby-friendly hospital concept was introduced in hospitals at different times from the year 2000 but has progressed only to a limited degree, and there are no national standards aligned with the updated model. The data about the application of the model is mixed, and while general hospitals report the application of the model in four maternity wards,[26] some respondents indicated that no maternity ward or hospital would fully comply with all the requirements of the concept.

There were additional important limitations recognized in the *Assessment of the Quality of Care for Mothers and Newborns*, commissioned by the Ministry of Health and UNICEF in 2016, including those related to staff shortages, insufficient training of health workers in the hospitals and indications that some outdated harmful procedures were still being applied. Similar to other areas of health, data records were substandard, including the absence of clinical case audits, shortage of national guidelines and protocols, and limited assessments of the beneficiaries' satisfaction with the quality of care and service provided. The study recommended, inter alia, to assess all hospital birthing facilities and to coordinate the development of action plans for following the recommendations.

3.3. Preventive checks in children aged 0 to 6

Preventive examinations of children are guided by the Rulebook on Preventive Healthcare,[27] which stipulates its content intended to provide: monitoring of the child's health status, growth and development; early identification of developmental risks; and advice to parents on appropriate child-rearing practices. Preventive examinations start in pregnancy, are performed by the chosen paediatrician and are most frequent during the first year of life, leading to a total of 11 preventive examinations envisaged for each child until the age of 6. Healthcare for young children also includes home-visiting services from birth until the age of 4 (described in more detail below), and assistants/mediators for social inclusion of Roma and Egyptians present in the three towns with the largest share of Roma and Egyptian populations who provide assistance for PHC services only.

While the *Growth and Development Register* is being developed by the Institute for Public Health, at present inadequate records and the absence of a database with information on children's coverage by different types of preventive examinations is hindering its monitoring. In practice, after the first year of a child's life the number of preventative visits by a paediatrician usually decreases because the law does not mandate the performance of such examinations, thus leaving it up to the choice of parents, assuming that they are informed about that possibility.

The respondents in the Study noted that the excessive workloads of paediatricians sometimes lead to the practice of preventative examinations lasting shorter than stipulated, which may result in some early signs of developmental delays being overlooked. **This could be harmful to young children as early screening and identification of potential risk factors for their health and development are proven to mitigate those risks, empower parents with strategies to support their children and minimize the need for costly specialized interventions later in life.[28]**

3.4. Home-visiting services

Research shows home visiting can be an effective method of delivering programmes for pregnant women and mothers with newborns. The family is the base for a child to develop and thrive, particularly in the early years. The most appropriate environment to talk to parents and assess child development and family needs is the community and the home. Support provided in the family's natural environment leads to better parenting practices and improves child and family outcomes.[29]

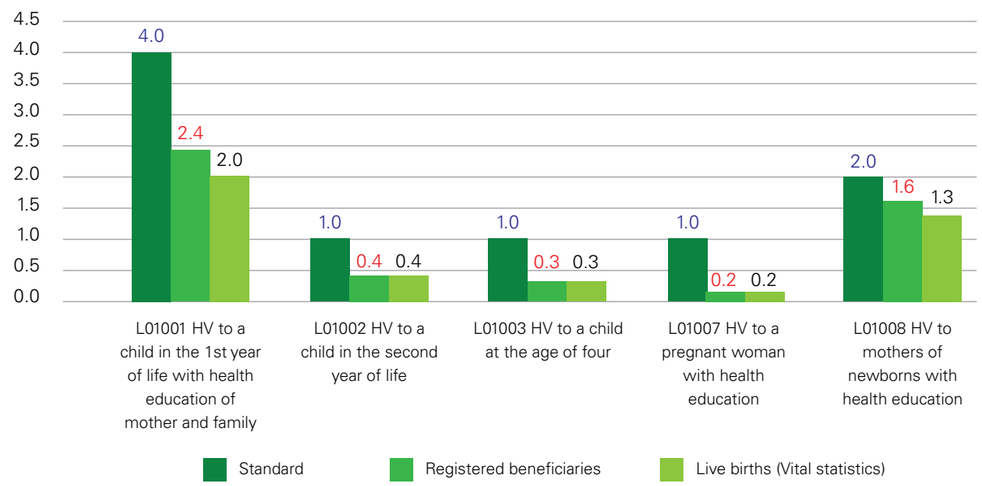
Disadvantaged pregnant women, parents and children are the ones most often falling through the cracks of the health, social care and education services, which makes a clear case for reaching out to them.[30]

The UNICEF Regional Office for Europe and Central Asia recommended adoption of a mixed (universal-progressive) home-visiting model for young children's wellbeing with: (1) a clearly defined *universal package of services* for all families; and (2) a *progressive component*, i.e. increased support for families with greater needs, including specialists and other sectors. The model has already been introduced by several countries in the region (Kazakhstan, Romania, North Macedonia and Serbia).

The *Rulebook for Primary Health Care* services and the *Basic Healthcare Decree*[31] define the content and scope of home-visiting services for mothers and children. The content entails, among other things: assessment of the socio-economic circumstances and relationships within the family; providing guidance and counselling; sharing knowledge and teaching skills; monitoring development and identification of signs of deviations from typical development; promotion of the importance of regular medical checks and immunization; and cooperation with other health professionals and resources in the community. In total, nine visits are envisaged, starting with one visit to pregnant women, followed by up to two visits to postpartum women, four counselling visits for infants in the first year of life, and one visit each in their second and fourth years.

The *Home Visitation System in Montenegro – Situation analysis and reform options*, developed by UNICEF in 2017[32] at the Ministry of Health's request, indicated that 87% of the total number of home visits in 2016 accounted for curative care, with the remaining focusing on prevention. According to the same study, the home visiting service's performance measured by comparing the plan with the actual delivery differed depending on the type of service. Patronage nurses overperformed in delivering curative care services by 15% in total, and at the same time delivered only 55% of planned services for pregnant women, newborn, infants and young children. The average number of home visits to infants in 2016 was only 2.4 at the national level, with significant discrepancies by municipality (from 7.3 in Cetinje to 0.1 in Plav). The graph below points to discrepancies between the average number of visits compared to the standards, registered users, and newborns (vital statistics), for each type of preventative MCH home-visiting service.

Chart 1: Mother and child health-related home visits, Health Insurance Fund, 2016



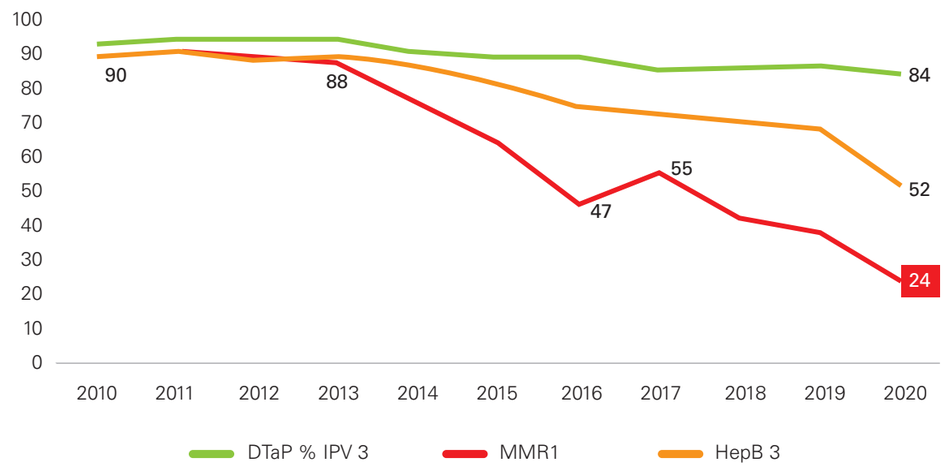
The study showed a significant country-wide variation in the average number of daily home visits performed by patronage nurses, against the set time for home visits, which has a potential impact on their content and quality. The additional concerns related to structural issues include insufficient capacities and resources (including human resources) to provide services, a lack of continuous professional development, a lack of service records, and the absence of performance indicators for preventative actions. Furthermore, interviews revealed that home-visiting services are organized through simple communication channels without a formal system in place or linkages between home-visiting services and other units within a single health information system. **Gynaecologists, paediatricians and maternity wards could play an important role in promoting the services of patronage nurses for the benefit of ECD in Montenegro.**

The Study recommended a two-phase approach for the improvement of preventative home visits for mothers and children. Phase I is a stabilization stage aimed at addressing the existing shortcomings in the performance and quality of preventative services. Phase II envisages expending services towards children in high-risk families, and those with developmental difficulties and disabilities. This approach would require a roadmap with a set of time-bound actions supported by performance indicators and a dedicated budget. Following the analysis, some investments in the improvements of quality of preventative home-visiting services have been made, mostly concerning the provision of training to home-visiting nurses.

3.5. Immunization

The *Law on Protection of the Public against Contagious Diseases*[33] stipulates the immunization protocol in Montenegro and defines several mandatory immunizations for children. The chart below, based on 2020 data, shows that the immunization coverage is not satisfactory, compared with the desired target of 95%.[34] Particularly low was the share for the first dosage of the vaccine against measles, mumps and rubella, which was 24% at the national level, and as low as 5–6% in some municipalities.

Chart 2: Immunization coverage for DTaP3, MMR 1, HepB3, Joint Reporting Form (JRF) 2021



Reporting year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
DTaP3/IPV/Hib	93.70	94.70	94.30	94.20	90.80	89.30	89.1	86.30	85.82	86.66	84.17
MMR1	90.00	90.70	90.30	88.00	76.10	64.00	46.6	55.10	42.1	37.33	23.88
HepB 3	90.30	91.10	89.00	89.80	86.60	81.60	75.3	73.32	71.93	68.08	52.19

According to MICS 2018 data, 54% of caregivers postponed a vaccination at some point, and 27% refused to inoculate a child under 5 years of age. The MMR vaccine seems to be causing a high level of concern among some parents: according to the MICS, 13% of women and 9% of men believe that it could cause serious adverse events following vaccination.[35]

In 2020, UNICEF, in collaboration with the Ministry of Health and the Public Health Institute, conducted the *Root Cause Analysis Immunization System Performance*[36] in Budva, Berane and Cetinje, which, inter alia revealed the following challenges:

1. **The absence of immunization goals clearly communicated to immunization service providers.**
2. **A lack of motivation for timely immunization on the part of immunization service providers.**
3. **Low accountability of service providers for achieving the immunization goals.**
4. **Some health workers are not fully up to date with knowledge on vaccine safety and contraindications.**
5. **Service providers lack interpersonal communication skills when speaking to caregivers about immunization.**
6. **Roma communities are unwilling to visit healthcare centres for vaccination (Berane).**
7. **An absence of interventions aimed at generating demand at the municipal level.**
8. **A strong anti-vaccination campaign in the media and on social networks.**
9. **A lack of knowledge among parents/caregivers about the benefits of immunization and the impact of vaccination on a child's health.**
10. **Participation of some healthcare professionals from the region in anti-vaccination campaigns on social media.**

The analysis provided recommendations for local- and national-level actions to address each of the root causes, through improved protocols and policies, by providing training to health workers, developing and implementing immunization system improvement plans, and demand-generation strategies.

3.6. Early detection of developmental delays and disabilities, and early intervention

The number of children with disabilities in Montenegro is not yet known. A module on Child Functioning was included for the first time in MICS 2018, which identified 6% of children aged 2–17 with functional difficulties in at least one domain.[37] There is a plan to set up a Disability Register, given that the current sector-specific registers are not linked with policy goals nor aligned with international treaties, which is limiting the use of information systems for policy monitoring.[38]

Early Childhood Intervention (ECI) is proven to improve a child's development and mitigate early developmental risks through services provided by involving the formal and informal social support networks with the capacity to support the child and the family as a whole. The programmes with the greatest impact are those that enhance the capacities of parents to support the development of children through child–parent interactions and their emotional attachment in natural settings.[39]

In terms of the health system capacities to provide services, the seven PHCs have so-called Centres for 0–14-year-old children with special needs, which operate regionally. The Centres face numerous limitations in their operations related to their insufficient number, the inadequate composition of staff and capacities to meet the needs.

The *Report on Mental Health Status of Children* in *Montenegro,*[40] noted inconsistencies in service provision among the Centres due to differences in their staffing educational background, which affects service quality and sustained delivery. This situation is to a certain extent mitigated by the project-based activities and services provided by non-governmental organizations, which is not considered a sustainable solution.[41] The Centre for Autism, Developmental Difficulties and Child Psychiatry was set up within the Clinical Centre in 2018, which appointed the first child psychiatrist in Montenegro in 2019. The aforementioned Report pointed to the need for hiring additional experts to ensure quality care. Apart from the health sector, early intervention services are also provided by Resource Centres within the education sector and by 15 Day-Care Centres which are part of the social and child protection systems described in subsequent chapters.

The *Analysis of the Multi-Sector Response to the Needs of Children with Disabilities in Montenegro,*[42] suggested a need for improvements in the realization of the rights of children with disabilities. **The main concerns were: the predominant medical model for assessments and interventions; limited coordination of actions between professionals at the local level; and significant pressure on the families to navigate the system, and synchronize the separate elements of the uncoordinated provisions offered.** The same review confirmed the observation of the respondents of the Study, who pointed out the absence of training opportunities for paediatricians concerning early detection and intervention.

The global data suggests that developmental screening, using a formal, validated screening tool, improves child's prospects for timely identification and provision of support because it is not always obvious to doctors,

childcare providers or parents if a developmental evaluation is recommended.[43]

3.7. Mental health

Care for persons with mental health conditions is provided in Mental Health Centres at the primary health level and it is available in eight out of the 18 PHCs.[44] The *Strategy for Mental Health Protection and Improvement* (2019–2023), which sets out priority areas of action, envisages no specific activities targeting pregnant women or women who have recently given birth. This poses a challenge for identifying and responding to the signs of stress and poor mental health among caregivers and children, which are more prominent for vulnerable families. For women, mental health problems are among the most common causes of pregnancy-related morbidity, and for men, fatherhood can also trigger struggles with mental health. It is important to stress the higher level of needs for mental health support of mothers with postnatal depression that affects 10%–15% of women in high-income countries, with substantially higher rates in low-and middle-income countries, with negative effects on child development. The treatments are more likely to be effective when intensive and extended by boosters and delivered in mothers' homes.[45]

3.8. Prevention of substance abuse

The impact on child development caused by a woman drinking alcohol during pregnancy, called foetal alcohol spectrum disorders, can lead to physical, behavioural and learning problems in a child. There is no known safe amount of alcohol during pregnancy or when trying to get pregnant, and no safe time to drink during pregnancy. Alcohol can cause problems for a developing baby throughout pregnancy, including before a woman knows she is pregnant.[46] Montenegro's *Strategy for Prevention of Drug Abuse* (2013–2020) has planned activities concerning training and awareness raising among healthcare workers for the reduction of alcohol abuse among pregnant women and women of reproductive age. The latest Action Plan for the Strategy included preventative programmes and reinforcement of the healthcare system's role in early intervention. There are, however, no actions specifically targeting pregnant women with alcohol addiction, except as part of the total population.[47]

3.9. Living in a clean and safe environment

According to MICS 2018, access to clean water and sanitation is at a high level in both the general population (99.5%) and in Roma settlements (98.9%). However, the percentage of households relying primarily on clean sources and technologies for heating, cooking and lighting is just 28% among the general population, and a mere 11% in the Roma settlements. According to the 2016 report, the air quality assessment regularly performed by the state authorities shows that the concentration of pollutants in some towns regularly exceeds the values permitted by the EU. This raises concerns about the impact of pollution on children's health. The 2012 data reported that the share of infant mortality attributable to air pollution exceeding the WHO Air Quality Guidelines fluctuated from 3%–9% in Podgorica, to 11%–31% in Pljevlja.[48]

4. NUTRITION

SDG Goal 2 calls on governments to take action to end hunger, improve nutrition and achieve food security. Two targets are specifically relevant for young children, because they draw attention to the importance of the poor and of people in vulnerable situations, including infants, having safe, nutritious and sufficient food all year round. They also set measurable targets for achieving internationally agreed goals on stunting and wasting in children under 5 years of age, and address the nutritional needs of girls and pregnant and lactating women.

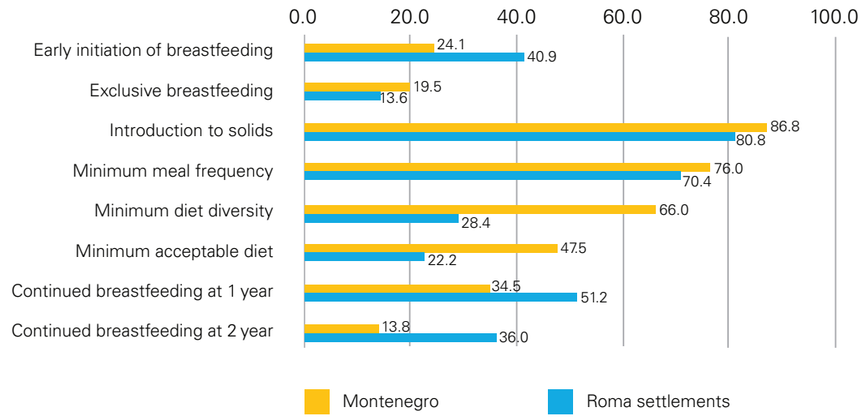
Proper nutrition in early childhood fosters healthy growth, brain development, protects children from illnesses, and increases learning potential. The NCF guides countries to assess the food security and nutritional status of vulnerable populations and strengthen connections between nutrition, health, education, water and sanitation, and child protection services, which requires the involvement of all relevant systems. Adequate nutrition also refers to maternal nutrition during pregnancy and after childbirth, because it affects her and the baby's wellbeing, and her ability to provide optimal care for a child.[49]

4.1. Nutritional status of children and mothers in Montenegro

The evidence on adequate nutrition of mothers and of 0–18-year-old children in Montenegro is limited. According to the 2017 Report under the Childhood Obesity Surveillance Initiative (COSI)[50], conducted by the Public Health Institute with the support of the WHO, among children under the age of 7, almost one in four boys, or 22.8%, and 11.9% of girls, are obese.[51] The MICS 2018 data suggests that 7.3% of children under the age of 5 are overweight. Being overweight is less prevalent among Roma children; however, one in five Roma children in the same age group are stunted (21%), while this figure for the general population is 7%.[52]

The benefits of breastfeeding for both the child and the mother are supported in numerous research studies and enjoy global consensus among the nutritionist community.[53] UNICEF and the WHO recommends exclusive breastfeeding during the first six months of life and continued breastfeeding until the age of 2 and beyond. Infant and young children feeding practices in Montenegro at the national level and in Roma settlements, based on the 2018 MICS, are presented in the chart below.

Chart 3: Infant and young child feeding, MICS 2018



One in five women in the general population, and one in seven Roma mothers, exclusively breastfed their babies for the first six months, which shows a slight increase compared to the 2013 data. The figures also suggest that diverse food is more prevalent in the top wealth quintile and among well-educated mothers. The minimum diet diversity and number of meals are provided to less than half of all children (48%), and to only one in five Roma children (22%).[54]

Poor maternal nutrition affects the baby while still in the womb, and during birth. Many pregnant women suffer from hidden hunger, i.e. micronutrient deficiency, that could lead to an inter-generational malnutrition cycle. The 2017 study by the Public Health Institute, supported by USAID and UNICEF, concluded that pregnant women are iodine-deficient. Women who used iodine-containing supplements prescribed by doctors had much better iodine intake.[55]

The importance of adequate nutrition is promoted in many strategies adopted in Montenegro. However, the lack of a single database on indicators relevant for monitoring the nutrition status of mothers, newborns and young children largely limits evidence-based policy planning and systemic efforts to address the various forms of malnutrition.

4.2. Support for breastfeeding

In 2017, the national *Code for Health Institutions and Health Workers on Marketing of Breastmilk Substitutes* was adopted, which includes a set of standards and professional behaviours for protecting, promoting and supporting breastfeeding. The national code has a more limited scope compared to the International Code, and violations can be noted in health institutions. Some initiatives are attempting to promote breastfeeding, but the coverage of pregnant women and mothers by these activities is not high, hence mothers are not adequately prepared or supported for breastfeeding. Several respondents suggested the need for additional education for health workers, as some still apply outdated approaches resulting in mothers failing to establish proper breastfeeding routines.

4.3. Nutritional counselling services in the healthcare system

Nutritional counselling for pregnant women and children is offered during examinations by chosen doctors, or at counselling services for pregnant women and reproductive health, and during home visits. Given the absence of country-wide guidance that defines adequate nutrition for pregnant women, newborns and children up to 6 years of age, diet is usually prescribed by gynaecologists and paediatricians on a case-by-case basis. Other public institutions that are equipped to provide advice related to nutrition are the Counselling Service for Adequate Nutrition within the Public Health Institute in Podgorica and the Hygiene and Epidemiological Services based in some PHCs. According to the interview findings, counselling services are underutilized, which stresses the need for promotion of the existing services. The Nutrition Service of the Public Health Institute was contacted with regards to nutrition by families of only two preschool children in 2017, and four in 2018.

4.4 Nutrition in preschools

There are limited initiatives to improve the nutrition of preschool children led by the Public Health Institute and implemented through cooperation agreements with 15 preschools from 10 municipalities,[56] which includes supervision regarding sanitary and hygiene conditions in the kitchens and the microbiological safety of the meals. An important limitation for increasing the coverage of this initiative is financial, given that the preschools are expected to contribute financially to this project. Recently, the Institute for Public Health analysed the meals offered in Podgorica-based preschools and provided recommendations on improving their quality by reducing the amount of fat, sugar and salt.[57] The proposed Strategy for early and preschool education (2021-2025) includes activities that aim to improve the quality of nutrition in preschool institutions.[58]

5. OPPORTUNITIES FOR EARLY LEARNING

Learning begins during pregnancy and occurs at home, in centre-based settings and during routine family activities that bring a lot of joy to young children. The education sector has an important role to play in supporting child development and early learning, and it can amplify the stimulation and care provided by families and other services. This huge opportunity is encapsulated in SDG 4 and Target 4.2 that issued the world a bold challenge of *providing all children with quality early childhood development and care by 2030.*[59]

Intervention in the early years is known to influence cognitive, language, physical, socio-emotional and self-regulatory development, and these, in turn, enhance the child's readiness for formal schooling. Quality ECE programmes address children's developmental needs holistically while involving parents and communities.[60] Despite the fact that early education offers an exceptionally powerful opportunity to break intergenerational inequity, vulnerable children are least likely to attend and benefit from quality inclusive early education settings.[61]

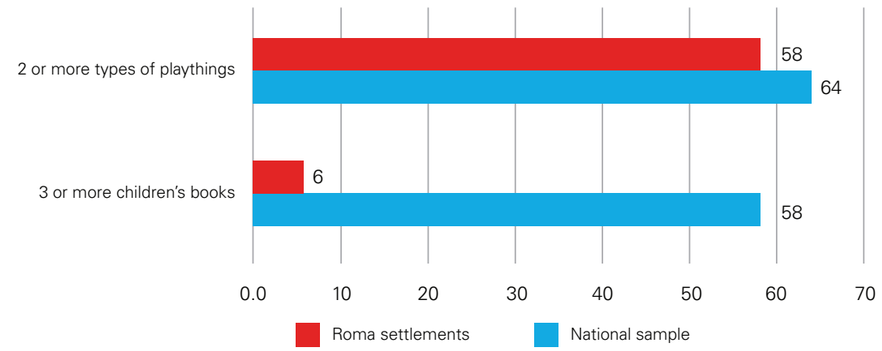
5.1. Early learning at home

Given the rapid brain development during the first years of life, the quality of the home setting and the child's interactions with caregivers greatly determine opportunities for development during this period. The best opportunities for early learning are offered by environments that stimulate curiosity, motivation, self-regulation and cherish language and cultural differences.

At home, activities that encourage children to be physically active and use their senses, talk, play and explore the environment and everyday objects during daily family routines are of the greatest value for their healthy development. Young children who receive loving attention from their caregivers are more likely to develop a secure attachment that leads to a sense of safety and security and offers a stable base from which to explore the world.[62]

The situation in Montenegro, based on the 2018 MICS data, shows that 58% of children under the age of 5 in the general population have at least three children's books, and 64% have at least two types of toys. When it comes to the availability of children's books for Roma children, this indicator is almost 10 times lower (6%).[63]

Chart 4: Access to Play & Learning Materials, MICS 2018

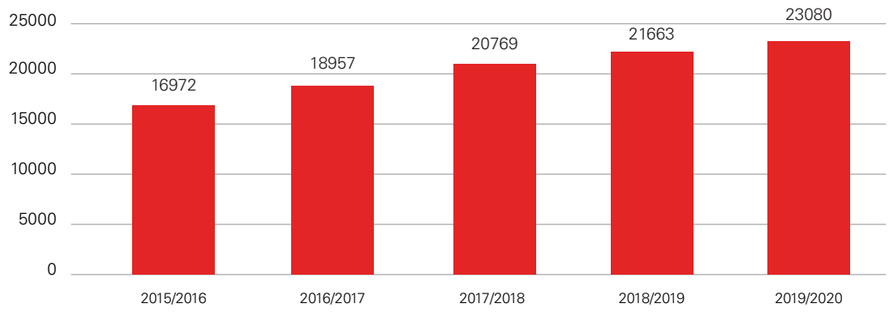


5.2. Preschool education coverage and programmes

Not only do children derive enormous benefits from preschool education – but it also has significant positive socio-economic implications for society at large, as evidenced in numerous studies.[64] Montenegro has recognized the importance of preschool education for children's development and has a good policy and legislative base for its expansion.[65] Under the *Preschool Education Law* (hereinafter the Law),[66] preschool education is available to every child and it is organized through provision in nurseries for 0–3-year-old, and in kindergartens for 3–6-year-old children. In 2019, the Ministry of Education (presently Ministry of Education, Science, Culture and Sport or MESCS) issued a recommendation to admit all interested children into preschools, reinforced by the *Preschool for All* campaign, supported by UNICEF, and the subsequent campaigns launched by the MoESCS aimed at raising awareness among parents and the general public about the importance of preschool education that should also contribute to better utilization of the preschool capacities in some municipalities. Public preschool education programmes are completely free of charge for socially disadvantaged families who are recipients of social assistance. The *Law* identifies the core programme, the short three-hour programme and specialized programmes. The core programme is approved by the National Education Council, while the other programmes are developed at the institution level, with the prior consent of the Council.

Before the outbreak of COVID-19, the total number of children in preschool education, in both public and privately-owned facilities, had been on a steady increase since 2015, leading to 72.62% coverage of 3–6-year-old children in 2018.[67] In addition, according to MISC 2018, the number of children between 36 and 59 months attending any early childhood development programme in the year preceding the survey also increased from 39.9% in 2013 to 52.8% in 2018. There was also an evident increase in the number of preschool units and groups both in public and privately owned facilities during the same period. However, COVID-19 negatively affected those positive trends, as will be discussed in Chapter 8.

Chart 5: Number of children enrolled in preschools, MEIS



The same education programmes are delivered in state and privately owned, licensed preschools. The total number of staff in both types of preschools is on the increase. The Law defines the size of groups, which ranges from eight for infants, to up to 25 children in the groups for 5- and 6-year-olds. In public preschools, the average number of children per group slightly decreased from 31.8 in 2015 to 30.3 in 2018. There are, however, considerable regional disparities in the number of children per group, with the smallest groups on average in the northern region and the largest ones in Petnjica, Podgorica and Herceg Novi.[68] The reasons for regional disparities – which might be the result of limited interest from parents and/or scattered settlements, and the distance to the nearest preschool setting, or a lack of financial resources to cover parental fees – require deeper analysis (as planned by MoESCS).

There is an overall trend that suggests fluctuations in the number of 36–59-month-old Roma children attending any form of ECE provision since 2015, with the lowest number of 93 children enrolled in the 2016/2017 academic year, and the highest number of 242 children enrolled in 2019/2020.[69] According to MEIS, the number of Roma children enrolled in the 2019/2020 academic year represents an increase of 92% compared to the previous year. The number of children with disabilities attending preschools and primary schools with referral decisions is on an upward trend. Specifically, related to the enrolment of children with disabilities in preschool education, the number increased from 66 children with disabilities enrolled in the 2019/2020 academic year, to 125 children enrolled in 2020/2021. Nevertheless, **these numbers are still quite low, indicating the need to invest further efforts to understand the causes behind these figures, increase the coverage, and enable systemic educational support for young vulnerable children.**

5.2.1. Preschool education for 0–3- and 3–6-year-old children

During the 2019/2020 school year 6,041 children were enrolled in nurseries, which is an increase of 65% compared to 2012, when 3,663 children attended this provision for 0–3-year-olds.[70]

The core programme for 3–6-year-old children includes activities that support key developmental domains and promote the inclusion of children with disabilities in mainstream preschools as the most effective way of identifying and developing their potentials.[71] The three-hour programme for 5–6-year-olds was introduced in 2016 for children who are not attending the core programme and it is available throughout Montenegro.

The preschool education quality assessment conducted in 2015 within the framework of the UNICEF's regional study,[72] coupled with the respondents' views from the present Study, identified overcrowded groups as a key obstacle affecting the quality of preschool programmes. In this context, teachers are struggling to devote sufficient attention to individual needs, to optimally use various pedagogical and teaching aids, and to monitor children's progress. The analysis has also indicated the requirement for improvements to the initial and continuous professional development of the workforce, which needs to reflect their actual needs. The mechanisms to support the improvements in quality include the work of the Bureau for Education, which monitors quality in all licensed educational institutions. The quality of preschool education must be tracked through continuous monitoring and evaluation to assess whether the actual practices are aligned with the legal requirements. Despite some positive initiatives that exist in this regard, Montenegro still lacks quality tools and procedures for an overall analysis of the outcomes of preschool children's growth and development.

The regional study, in which Montenegro participated in 2017, which was focused on preschool education quality, recommended the inclusion of a child's portfolio as a tool for enabling the monitoring of a child's development in preschool settings. This initiative has been implemented across all preschools in Montenegro.

5.2.2. Equity of preschool education

Global access to ECD programmes has been uneven both between and within countries, leaving vulnerable young children disproportionately excluded from quality pre-primary education. The strongest universal factors affecting access to pre-primary education is household income, the mother's level of education and geographical location.[73]

Inclusion must start in the early years when the foundation for lifelong learning is built and fundamental values and attitudes are formed. Inequalities in learning and other child development outcomes emerge at this age, which requires acting for inclusion within preschool education.[74]

In Montenegro, the MoESCS and UNICEF have been working intensively to support greater participation of Roma and Egyptian children in preschools, through capacity building of preschools and collaboration with multiple stakeholders.[75] The MoESCS also provides free enrolment to preschools for Roma children in the situation where both parents are unemployed. However, key factors that require ongoing attention at the system level are the disadvantaged socio-economic position of Roma families that limits parents' ability to contribute to additional educational costs, and the distance to the nearest preschool setting, which prevents some young children from attending preschools with their non-Roma peers. Actions likely to improve equitable enrolment to ECE of Roma children are: the provision of free transport; improved capacities of teaching staff to respond to the linguistic and cultural needs of Roma families; Roma families being better informed about the existing educational opportunities; professional recognition of assistants for social inclusion of Roma and Egyptian; and enhanced institutional capacities and coordination for supporting the early education of Roma children.

Children with disabilities are educated in regular preschools. The *Law on Education of Children with Special Educational Needs*[76] defines referral procedures, which are supported by the *Instruction for Referral*

of Children with SEN developed by the MoESCS in 2014.[77] These documents promote a conceptual shift from a medical model towards a model based on the individual needs and the rights of the child and the family to make decisions. The actual referral, concluded by the multi-professional local Commissions, with the participation of the parent and a preschool teacher, guides a decision about the best educational placement for the child. An increased number of children with SEN referrals is a positive step indicative of the greater determination of both parents and the institutions to provide improved conditions for their learning. UNICEF, the Resource Centres and educational institutions launched several initiatives, including support to the professional development of experts within the Centres, aimed at increasing their capacities for the provision of early intervention services, and for supporting inclusive education efforts. One of the challenges is how to expand these services to children who do not reside in Podgorica or Kotor, where the Resource Centres operate.

Additionally, at the preschool level, UNICEF supported the provision for children with disabilities through the early intervention training provided to all preschool staff.

Two types of services are developed to support children from other vulnerable groups to access the mainstream provision. In 2017, the Law introduced *outreach services* for children in remote rural areas, initially established in the north, and then scaled up to the central and coastal regions in 2019. The services are free of charge and they are currently operating in 15 municipalities. Another innovative ECD service was introduced in 2017, aimed at enabling *children without parental care* accommodated in the "Mladost" Children's Home to attend regular preschools. **Within a broader commitment to monitoring children's developmental outcomes, it would be important to include these emerging initiatives in the overall evaluation of the performance of ECD services, and a plan for the systematic measurement of children's outcomes**.

6. RESPONSIVE CAREGIVING

The opportunities for nurturing and responsive interactions between parents and children, for early learning and positive parenting, are vital for a child's development. The NCF defines nurturing care as the ability of parents to notice and respond to children's signals in a timely and appropriate manner.

The responsive care domain of the NCF is considered foundational because responsive caregivers can also better support the other four domains of the Framework.[78]

Research suggests[79] that nutritional deficiency in infants and young children is more prevalent in families where parents are less involved in responsive care. Parents with mental health problems, and particularly depressed mothers, need access to services so that their conditions improve and they are able to develop a close attachment with their children, through interactions, play and care. Many parents also need support with providing adequate stimulation without harsh disciplining of children.[80] Families and other caregivers need environments that enable them to put children first. They need the knowledge, resources and opportunities to provide nurturing care for their young children. Policies, programmes and services should be able to help them achieve this goal.[81]

6.1. Interactions between children and parents in Montenegro

According to MICS 2018, 91% of 2–4-year-olds in the general population had the engagement of an adult with at least four activities that foster learning.[82] The figure is much lower for Roma children and stands at 50.7%. For the general population, the average number of activities children had daily with their fathers was 3.1, and 4.9 with their mothers. In the case of Roma children, 1.8 daily activities were supported by fathers and 2.8 by mothers. The social status and parental education levels play a critical role in the intensity of interactions between parents and children, resulting in parents from the bottom quintile and less educated parents being significantly less involved in activities with their children compared to other quintiles and levels of education (MICS, 2018). These findings are important for the planning of possible intervention strategies.

Montenegro has very few interventions or programmes aimed at responsive parenting, with some notable ones described below.

6.2. Parental leave

The global Nurturing Care Framework promotes maternal/parental leave, as it enables the establishment of a strong emotional bond between parents and children, and facilitates initiation of breastfeeding that can be sustained over a longer period. This entitlement also increases the probability that the health and developmental needs of infants will be met. Additionally, when fathers use parental leave, they become more involved in the life of the child and the family, and may support mothers in persisting with breastfeeding, which has numerous benefits, including a reduction in the prevalence of postpartum depression.[83]

This supports a better gender balance in family decision making, improves the gender equality of labour and helps the economic empowerment of women and families.[84] The Montenegrin *Labour Law*[85] stipulates maternal/parental leave and sets the entitlements associated with them. The leave can be split between mothers and fathers, and employed women who return earlier to work are entitled to an additional 90-minute break for breastfeeding. According to the records of the Institute for Social and Child Protection, only 3% of fathers used parental leave in 2018.

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6.3. Parenting programmes

Parenting programmes are interventions which aim to improve interactions between parents and children and their knowledge and practices, mostly through group sessions or home visits. Recent reviews of parenting programmes in low- and middle-income countries noted their positive impact on a child's cognitive, speech, psychological and motor development. Furthermore, according to the INSPIRE strategies developed by the WHO in 2016,[86] parenting programmes strengthen families and support effective strategies for reducing the risk of poor conduct towards children and various forms of child violence.

The importance of supporting parents is recognized in Montenegro's policy framework in the *Strategy on Prevention and Protection of Children against Violence* (2017–2021), the *Strategy for Early and Preschool Education* (2016–2020 and the forthcoming Strategy 2021-2025) and the *Strategy for Exercising the Rights of the Child* (2019–2023). Since 2018 many preschools, health centres and CSOs have been delivering the group-based *Parenting for Lifelong Health for Young Children* (PLH) programme with the support of UNICEF and the European Union. This 12-week programme supports parents in establishing and maintaining nurturing relations with their 2–9-year-old children and thereby preventing the risks of violence against children. The programme has also shown a positive impact on preventing behavioural problems in children and reducing the level of stress and depression in parents.[87] The programme was developed by international experts with support from the WHO and UNICEF and it targets low- and middle-income countries. By the end of 2020, 472 parents and caregivers had signed up for the programme in Montenegro, of whom 10% were fathers.

Following a positive evaluation of the Parenting for Lifelong Health programme in 2018, the parliamentary Committee on Human Rights and Freedoms recommended scaling up the programme to all municipalities in Montenegro, which requires coordinated actions by all the relevant ministries.

UNICEF has supported scaling-up efforts through the development of national supervisors and trainers and by commissioning a study Scaling up Parenting for Lifelong Health in Montenegro; A feasibility assessment in 2021.[88]

There is also a licensed, free-of-charge Parents' Helpline provided by the NGO *Parents* introduced with support from UNICEF and the European Union in 2017. Online counselling is also provided.

7. SAFETY AND SECURITY

The NCF upholds the safety and security of young children and promotes the importance of environments free of psychological dangers, emotional stress and environmental risks. All young children need safety in their settings, access to food and clean water, and good hygiene. Equally important are mechanisms to identify and respond to signs of family violence and violence against children, as well as of exploitation, neglect and abuse.[89]

For families living in extreme poverty or struggling to survive, it is particularly difficult to ensure proper care and to meet the basic needs of children, such as healthcare and education. Social and child protection services have a critical role to play, by protecting children and in securing financial and other forms of support. This goal can be achieved only if other services and the communities are also involved in creating safe environments and in preventing, detecting and reporting harmful actions to the relevant authorities.[90]

The Council of the European Union has recognized the early years as critical in shaping children's development, which puts ECD policies and services among the key tools for supporting children's safety and security, for preventing and tackling poverty and social exclusion and breaking the intergenerational cycle of disadvantage.[91]

7.1. Birth registration

The birth certificate is an important strategy in securing every child's right to a name and nationality, which is the first step to ensure their recognition before the law, and assurance that no rights violations will go undetected. Some 7,500 babies are born in Montenegro every year. The MICS data shows that 99.4% of children under the age of 5 were registered in 2013. According to the 2018 MISC data, a total of 96.2% of children under the age of 5 in Roma settlements were registered, with a similar share of 5–17-year-olds (98.5%).[92] This is an increase compared to 2013 when 94.5% of Roma children under the age of 5 were registered.[93] In 2015, through amendments to the relevant legislation, Montenegro introduced a court-based procedure for establishing the time and place of birth for persons born outside of medical facilities, which has improved birth registration. Furthermore, in 2019, the Ministry of the Interior and the Ministry of Labour and Social Welfare, with the support of UNHCR, facilitated the birth registration of children born to mothers without an ID or who abandoned their newborns.

7.2. Preventing the removal of children from their families and institutionalization

The adverse impacts of institutionalization, particularly for young children, are meticulously described in the literature along with the impact on their neurological, cognitive and socio-emotional development. The *Strategy for Exercising the Rights of the Child* (2019–2023) recognizes that "a functional biological family provides the best environment for the child to develop in", and identifies several services, such as counselling services for children and parents, family outreach services, day-care for children at risk, etc."[94] When children are deprived of parental care, the Strategy puts obligations on the state to provide special protection, which includes foster family placement, adoption and, in exceptional cases, placement in adequate childcare institutions. Montenegro has conducted a comprehensive reform of the social and child protection system over the last decade, supported by UNICEF, UNDP and the EU,[95] which led to a significant reduction in the number of children in residential care and the expansion of the number of services provided at the family and community levels.[96]

The *Analysis of the Work of Centres for Social Work in Montenegro*,[97] as the key gatekeeping institutions, found that the main challenges remain: a shortage of staff and other staffing issues; a lack of effective tools for risk identification at the community level; inadequate outreach functions; insufficient involvement of various community actors; limited emphasis on beneficiary empowerment; considerable organizational challenges; and the limited scope of services they can refer beneficiaries to. In response to this situation, a *Family Outreach* pilot service was initiated in 2016, with support from UNICEF and the then MLSW (now called the MFSW), intended to provide support to families at risk of child abandonment, neglect or abuse. Since 2017, the service has been provided by the licensed NGO "Family Centre" in several municipalities. The 2019 Activity Report of the MLSW confirmed that 65 families with 184 children, 23 (13%) under the age of 3, benefitted from the service, and no child was removed from their family while in the programme. In 2020, the family outreach worker service was operational in 10 municipalities in Montenegro. In the *Strategy for the Protection of Children from and Prevention of Violence* 2017–2021, the MLSW committed itself to making the service available in all municipalities by the end of 2021. However, due to the disruption in financing in 2021 by the Ministry of Finance and Social Welfare, at the time of finalizing this publication, the service is no longer available in the municipalities of Podgorica and Niksic, and in the municipalities of Bijelo Polje, Herceg Novi, Kotor, Tivat, Budva and Cetinje family outreach workers are engaged part-time, which decreases the prospects for expanding the service to additional families at risk.[98] This service is critical, given that families are at high risk of abandonment and domestic violence, which is further complicated by the COVID-19 pandemic, when families need more intensive support for meeting their basic living needs and providing for children's health and education.

Another form of a provision intended to support assisted, community-based living is *day-care services*, which cater for children, young people, adults with disabilities and children with behavioural problems. In 2020, 17 day-care centres across Montenegro, introduced in collaboration between the MLSW, local self-governments and civil society, supported almost 270 children and young people with disabilities under the age of 27. Children under the age of 5 accounted for around 14% of all children.[99] However, Day-Care Centres are experiencing problems with financing due to the Ministry of Finance and Social Protection's announcement that it would replace the national financial support to this service with full financial coverage provided at the local level, as of 2021.[100]

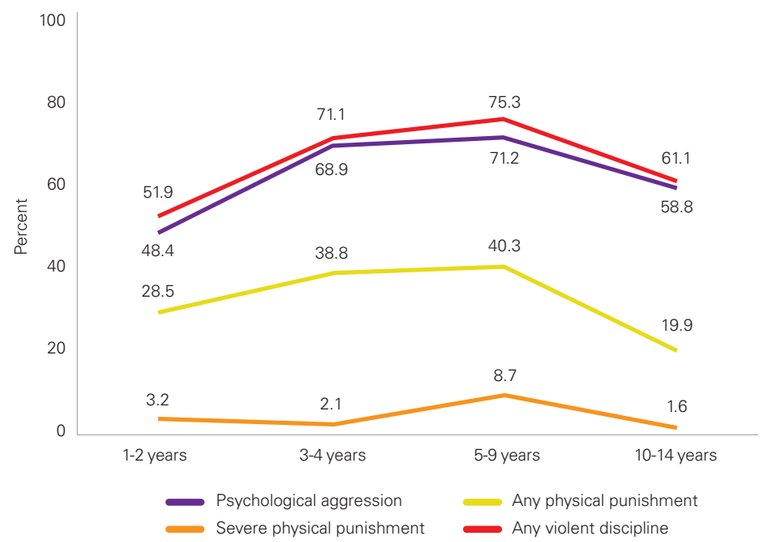
Furthermore, consistent with international standards, the *Law on Social and Child Protection* mandates that children under the age of 3 cannot be placed in residential care, except in critical circumstances.[101] In the course of the reform, the number of children in residential care in the "Mladost" Children's Home was halved between 2008 and 2017. At the end of 2020, "Mladost" accommodated 79 children, but the figure fluctuates over time. One or two babies are occasionally placed in "Mladost", which is indicative of the insufficient availability of alternatives in urgent situations. Finally, one small group home, simulating a family environment, was established in Bijelo Polje,[102] which in late 2020 housed nine children with disabilities without parental care.[103]

7.3. Violence prevention and protection of children

Young children globally fall into the group most often exposed to corporal punishment, which may cause uncontrolled fear and stress in young children that can lead to the child's distrust of adults or the manifestation of fear through aggressive behaviour.[104] In Montenegro, 65.8% of 1–14-year-old children were exposed to at least one form of mental or physical punishment[105] by an adult family member in 2018.[106]

Only one in 10 interviewed caregivers from the general population, and one in five Roma parents, believe that children should be physically punished, which indicates an interesting contrast to the actual prevalence of violent disciplining. Mothers justify physical punishment more often than fathers, and this is also the case with younger parents, those in the bottom social quintile and those with lower education levels. Furthermore, 83% of 2–14-year-old children with functional difficulties are exposed to violent disciplining, compared to 67% of children without such difficulties. Eleven percent of Roma children are exposed to severe physical punishment compared to 4% of children in the general population. Young children in the age groups 3 to 5 and 5 to 9 are more exposed than older children.

Chart 6: Violent disciplning of children in Montenegro, MICS 2018



When it comes to the prevention of violence, support for parents to develop non-violent disciplining and positive parenting skills is limited. Apart from the above-discussed *Parenting for Lifelong Health for Young Children* programme, which has limited geographical coverage, relevant strategies anticipate the development of parenting programmes to improve parental sensitivity and the prevention of violence.[107] Regarding the number of cases of violence against children registered by Centres for Social Work, in 2019, there were 659 cases of children victims of violence, which is an increase of 47% compared to 2017, when 448 cases were reported.[108] According to the study's respondents, this is a result of campaigns to raise awareness about violence against children. However, this number decreased significantly in 2020.

The information provided by the Public Health Institute indicates a very low number of cases of violence registered in the health sector. In 2020, the MoH, UNICEF and WHO developed guidelines aimed to improve the sensitivity and contribution of health service providers to identifying, reporting and referring cases of abuse, neglect and violence against children.[109] Another still underutilized strategy likely to improve practice in this regard is the already discussed home-visiting services. An additional significant problem is the lack of therapeutic work with child victims of violence and psycho-social treatment for offenders.

In the education sector, work on the prevention of violence against children has intensified, including through the Montenegrin Education Information System (MEIS).

Emerging positive initiatives are the national helpline for children initiated in 2018, delivered by the "Mladost" Children's Home in Bijela, which also runs a shelter for child victims of violence, and a licensed helpline for victims of domestic violence run by an NGO in Niksic. The *Strategy for the Protection of Children from and the Prevention of Violence* envisaged the creation of a *National Children's Home* in 2020, intended for child victims of sexual and other forms of severe physical violence, guided by positive international experiences suggesting an increase in the reporting of cases of violence. This activity is under the Ministry of the Interior and the Ministry of Finance and Social Protection, with no funding currently allocated for this purpose.

7.4. Cash transfers

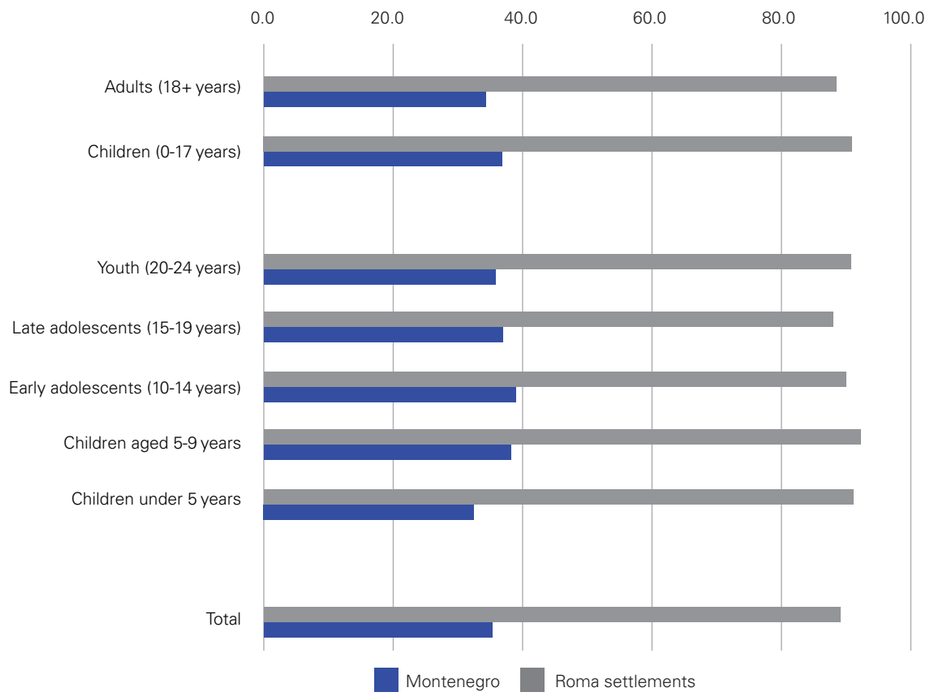
The law stipulates a set of benefits in the framework of social and child protection. As a rule, cash transfers should protect disadvantaged families and support them to meet their basic needs. The significance of cash transfers is best illustrated by the fact that the risk of poverty, according to 2019 data, was 29.5% before transfers, but reduced to 24.5% after transfers were introduced.[110] The data shows that the risk of poverty increases with the number of dependent children in the family, and it is greatest for families with three or more children, at 45.9% The 2017 data indicated that children under the age of 17 are more exposed to the risk of poverty (31.7%), which is 3% lower than in 2013, but above the EU average which stands at 20%.[111] On the other hand, according to MFSW data, close to 10% of children under the age of 18 were beneficiaries of the child allowance in 2020,[112] suggesting that at least 22% of children at risk of poverty were not covered by this allowance. However, the government has announced the expansion of child allowances with the intention of covering all 0–6-year-old children.[113]

For the first time in 2018, the MICS examined material deprivation in the general population and in Roma settlements in Montenegro,[114] which records the percentage of persons living in a household that cannot afford at least three out of nine predefined items.[115] Among households with three or more children, the most prevalent deprivation refers to their

inability to face unexpected expenses, which among the general population stands at 69%, and at 97% in Roma settlements.

Among the general population, 33% of children under the age of 5 are materially deprived in three or more dimensions, which is the case for as many as 91% of Roma children of the same age.

Chart 7: Material Deprivation Rate, MICS 2018



Global data points to an increase in minimum wages as a strategy with the potential to improve the lives of millions of children whose parents work in the formal economy.[116] In 2019, Montenegro increased the statutory minimum monthly wage from €193 to €222, which covered only 35% of the consumer basket. The minimum wage will increase to €250 in autumn 2021.[117]

In this situation, cash transfers remain critical means for improving the quality of life and empowerment for the independent life of individuals and families. The largest group of benefits within the child protection segment refers to child allowances, which are paid regularly.[118] **To expand the life opportunities for almost one in three children in Montenegro at risk of poverty,[119] the scheme should be improved. Furthermore, the impact of expansion of the allowance to all children under 6 should be monitored.**

8. IMPACT OF THE COVID-19 PANDEMIC ON YOUNG CHILDREN, FAMILIES AND SERVICES

The global COVID-19 crisis brought significant interruptions to the lives of young children caused by disruptions to various services, lockdowns and a major economic impact on families and societies. Access to regular health services has been affected with a significant impact on regular preventive care, vaccinations, access to drugs, and the overall capacities of services to monitor children's development and to provide support to parents if risk factors are identified.

Additional challenges to young children are related to their nutritional status and risk of malnutrition. Namely, 47 million children under the age of 5 already had acute malnutrition before the pandemic, and an estimated additional 6.7 million children are now at risk.[120] Contributing factors are: less proactive detection mechanisms; more limited access to fresh food supplies; and a lack of meals provided in educational settings. Early education has been relatively neglected within the education sector, which, otherwise, may serve as a critical protective measure to support young children and their families during the COVID-19 crisis by providing children with a nurturing environment, offering a safety net and providing consistency and predictability to their lives.[121]

Other major effects of the pandemic on young children are: changes in the home environment and the capacities of parents to support them. Increased isolation at a time of great pressure on families and increased stress, combined with less access to financial support mechanisms, can lead to additional risks of experiencing greater violence in the home, which is aggravated for already vulnerable children. Children in vulnerable households and those with multiple factors of adversity are most affected.[122] Global data reveals that without urgent action the number of children living in poverty could increase from 586 million to up to 672 million, with key consequences for children in low- and middle-income countries.[123]

A Rapid Social Impact Assessment (RSIA) of the COVID-19 outbreak in Montenegro, conducted by the UN in June 2020,[124] aimed to provide deeper insights into the impact of the evolving crisis on the most vulnerable groups and to identify the groups in society that are suffering the most.[125] The parents and caregivers that took part in the Assessment reported households' decreased ability to afford products for children under the age of 6. The Assessment also highlighted important protective measures for children, and called for targeted, vigorous social and child protection system responses that integrate cash assistance and quality, inclusive services. Special measures recommended to protect vulnerable children are: the further strengthening of kinship and foster care; the monitoring and protection of the rights of children in residential care; expansion of psychological support to children through helplines to ensure support for caregivers; continuation in providing nutrition support; tailor-made hygiene kits; clothing; and the provision of medications, when necessary. The measures should be in place to guarantee the continuous availability and inclusiveness of health services, and the provision of intensive education-related support and equipment for distance learning for children from vulnerable groups. The importance of the provision of continuous information to members of vulnerable groups about the availability of social services was also stressed, which mirrors global learning about the priority needs of families with young children during the pandemic.[126]

In addition, below are some highlights reflecting the impact of COVID-19 on indicators from the five domains of the nurturing care framework:

- Data on the coverage of children born in 2019 with the first dose of the vaccine against measles stood at around 24% in April 2021, which is a further decline from the already declining figure of 42% in 2018. Such low coverage may lead to a measles epidemic.[127]
- There have been media reports about COVID-19 positive women who were separated from their newborns after delivery.[128] The global guidance suggests support for all new mothers, including those who test positive for COVID-19, to breastfeed safely, to provide skin-to-skin contact and to practice rooming-in with their babies.[129]
- Relevant early indication of impacts on the disruptions of preschool services suggests a drop in the number of enrolled children in the 2020/2021 academic year in comparison to the previous year. According to MEIS data from December 2020, 21,318 children were enrolled in preschool education in the 2020/2021 academic year, which represents a decrease from the 2019/2020 academic year, when 23,080 children were enrolled.[130] These figures are additionally concerning regarding preschool enrolment of Roma children, which decreased from 242 children enrolled in 2019/2020, to 198 children enrolled in the 2020/2021 academic year. Children from vulnerable groups are not only missing optimal stimulation and learning opportunities in a safe and stable preschool environment, but they are also no longer receiving the free meals provided by preschools. On the other hand, some admirable initiatives were implemented to stimulate child development at home, for instance #IgrajSeDoma.
- A positive trend is observed concerning the enrolment of children with disabilities in preschool education, with a significant increase from 66 children with disabilities enrolled in the 2019/2020 academic year, to 125 children enrolled in 2020/2021. Further analysis is needed to shed light on these contrasting trends observed during the COVID-19 pandemic.
- Development of a platform for online learning, teaching and collaboration[131] is a new initiative implemented with the aim of enhancing the quality, inclusiveness, relevance and resilience of the education system. It will also provide opportunities for preschool educators and caregivers to access interactive activities to strengthen early learning at home, including in the context of COVID-19. However, according to RSIA data from 2020, 13.3% of households with children under 18 do not have access either to a computer or to a tablet connected to the internet, which increases the risk of their exclusion from participating in distance learning.[132] It is for this reason that the government and all the relevant actors and stakeholders need to invest major efforts into reducing the digital divide, along with activities aimed at harnessing the potential of digital technologies to improve the quality of education.
- Due to the complex epidemiological situation during autumn 2020, only one institution was able to offer the Parenting for Lifelong Health programme. In 2021 the pilot ParentChat programme was launched, which is delivered using online platforms. The face-to-face Parenting for Lifelong Health programme was also resumed in 2021.
- It is necessary to step up measures to protect children from violence, including online violence, given the increased use of digital media by children in the context of the epidemic, with a special focus on the role of caregivers and teachers. Child-friendly violence-reporting mechanisms should also be enhanced and promoted, especially during the pandemic when traditional channels may not be easily available. The significant decrease in the number of cases of violence against children registered by Centres for Social Work during 2020 deserves detailed analysis.

The immediate effects of this pandemic are likely to be compounded with an economic recession and further weakening of the situation of vulnerable households, with a disproportional effect on young children, given their critical stage in life. ECD experts have called for states and donors to invest in holistic programmes as a pathway to economic and social recovery.[133] Access to services and organized and predictable government support, including financial support, remain a priority.

9. ENABLING ENVIRONMENT FOR YOUNG CHILDREN

All the services supporting young children need to be harmonized, as all five domains of the NCF are needed for children to reach their full potentials, and all aspects of a young child's development are interdependent and mutually reinforcing. Potential improvements in service coverage and quality in one domain, coupled with limited or entirely absent services in other domains, are unlikely to meet the needs. This is particularly the case for vulnerable families who tend to need a significant level of support across all domains. Any actions aimed at improving nurturing care require a cross-sector approach that calls for the development of a comprehensive ECD strategy.

Additionally, the mobilization of adequate financial resources to expand ECD is critical. The recent analysis commissioned by UNICEF with the support of the EU titled "The Potential of Additional Investment in Early Childhood Development in Montenegro"[134] concluded that public investments in ECD policies and programmes in 2016 (including social protection with 48% of total costs) amounted to 1.3% of GDP, or 2.4% of the 2016 state budget. Without social protection expenditures, the percentage of GDP investment would be only about 0.68%. This investment is below the targeted 2% of GDP recommended by the global ECD Action Network, and the amount required to operationalize the G20 ECD initiative. It is also below the estimated 0.8% of GDP required to provide the World-Bank-defined 'basic package of services'[135] excluding social protection and significantly lower than the estimated 3% of GDP needed in middle-income countries to offer the enhanced package of services,[136] which excludes social protection. Shortfalls in funding are impeding access to equitable quality ECD services.

10. CONCLUSION AND RECOMMENDATIONS

The research into ECD services mapped several strategies, policies, services and programmes in all five domains of the NCF. The country has a good basis to provide services and measures that optimize support to families and maximize opportunities for young children to achieve their full potentials, but improvement is needed in almost all areas.[137]

The Study recommends enhancements in the *health sector* in regard to perinatal care that needs to be aligned with international standards and greater commitment to promotion and institutionalization of 'baby-friendly' services. The frequency and quality of preventive examinations of and home-visits to children need to be better aligned with the established standards. Monitoring of child development to enhance early detection of developmental delays and to provide early intervention in line with evidence-based practices needs to be improved. In the area of *nutrition*, the existing nutrition counselling facilities analysed in the Study are underutilized. Breastfeeding promotion programmes, in particular, require further efforts to guarantee their continued implementation. *Early education coverage*, even though improved, has not reached all children, particularly vulnerable children, and efforts to improve the quality of pre-primary education are needed. *Parenting skills programmes*, despite their proven value for all, and particularly for vulnerable families, are offered only in some municipalities. *Safety and security* services, e.g. family- and community-based services, are limited, which is slowing down the pace of deinstitutionalization. The same is true for the publicly funded shelters for children and mothers who are victims of violence. The implementation of counselling and therapy services needs to be strengthened. Families facing multiple risks require integrated support through cash benefits and services.

The Study identified: a *lack of national implementation protocols*; an *absence of regulations for monitoring and evaluating the quality* of services; and *children's outcomes*. Improvements in the *professional development of staff*, through ongoing *training opportunities and supportive supervision*, tied with a need for *improved clarity of professional roles* and enhanced *collaboration* within and across sectors and services, were identified across all sectors. Investments in ECD were also found to be insufficient.

To achieve the above, the following principles, approaches and strategies are recommended:

- Develop a costed national ECD strategy for coordinated actions and allocate sufficient financial resources for its implementation;
- Step up inter-agency collaboration at the policy planning, implementation and monitoring, and service delivery levels (e.g. protocols, data exchange, referrals and joint training);
- Increase service availability (e.g. nutrition counselling and therapy) and upgrade service quality;
- Ensure that all communities have equal access to ECD services (e.g. with family outreach worker services and *Parenting for Lifelong Health* being available in some municipalities only);
- Introduce additional measures to ensure equitable access of vulnerable groups to ECD services with an emphasis on children from the bottom social quintile, children with disabilities and Roma children;
- Address the issue of excessive workloads affecting the scale and quality of services offered (shortage of nurses for home visits, heavy workloads for paediatricians and case managers from Centres for Social Work);
- Provide training to develop the competencies of the ECD workforce and improve communication with parents for influencing positive practices (e.g. improved immunization rate and breastfeeding practices);
- Provide parents/caregivers with a range of support services to empower them and improve their capacities for providing responsive care that addresses multiple risks; improve monitoring and evaluation of nurturing care services.

Proofreading: Peter Stonelake

Annex 1: List of interviewees:

During the research, experts from various fields were interviewed, including: Aida Ramović Piranić (PHC Podgorica), Ana Vujinović (Association Parents), Anita Marić (Bureau for Education), Bojana Miletić (Institute for Social and Child Protection), Day-Care Centre Nikšić (Radojka Koprivica, director, and Miloš Perović, coordinator), Ena Grbović (Public Health Institute), Enisa Kujundžić (Public Health Institute), Jadranka Miljanić (PHC Podgorica), Kristina Mihailović (Association Parents), Lidija Marković (director of the privately owned kindergarten "Kućica"), Marijana Blečić (Pedagogical Centre), Milica Dukić (Ministry of Health), Milovan Jovanović (PHC Podgorica), Miro Knežević (Ministry of Health), Nebojša Kavarić (PHC Podgorica), Paša Divanović (PHC Podgorica), Senad Begić (Institute for Public Health), Svetlana Sovilj (Ministry of Labour and Social Welfare), Tatjana Novović (Pedagogical Centre), Vesna Pejović (Ministry of Education), "Dragan Kovačević" Preschool Nikšić (a pedagogue, a lawyer, an accountant and a nutrition specialist), Zora Odavić (PHC Podgorica), Zorica Đorđević (Institute for Public Health), Maja Kovačević, Ivana Ceković, Nela Krnić, Nada Đurović Martinović, Danilo Smolović, Željka Popović, Ida Ferdinandi and Vladan Golubović (UNICEF staff).

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95. Social and Child Care System Reform: Enhancing Social Inclusion, IPA 2010, IPA 2014.

96. IDEAS (2019), "Analysis of the Work of Centres for Social Work in Montenegro", Podgorica: UNICEF, p. 6.

97. The analysis was conducted by the Centre for Research and Social Development IDEAS in cooperation with the Institute for Social and Child Protection at the request of the Ministry of Labour and Social Welfare, with the expert and financial support from UNICEF Montenegro.

98. Published in daily Vijesti on 20 May 2021: Crno na bijelo: Uputili smo amandmane na budžet, vratićemo usluge dnevnih centara za djecu sa smetnjama u razvoju... (vijesti.me).

99. According to 2019 data.

100. Daily Vijesti. Ibid.

101. Including when the support provided to the family cannot ensure a continued placement of the child within the family, or when it is not possible to find foster care placement, or it is not in the best interest of the child.

102. The construction of the small group home was supported by the US Embassy, while the equipment and training for staff were provided by the European Union, UNICEF, UNDP, the Ministry of Labour and Social Welfare and the Municipality of Bijelo Polje.

103. Annual report of the Ministry of Labour and Social Welfare for 2020.

104. WHO, UNICEF, the World Bank Group. Ibid.

105. According to MICS definitions, physical punishment is defined as shaking the child, hitting or slapping him/her on the hand/arm/leg, hitting him/her on the bottom or elsewhere on the body with a hard object, spanking or hitting him/her on the bottom with a bare hand, hitting or slapping him/her on the face, head or ears, and beating him/her over and over as hard as possible. Severe physical punishment includes slapping or hitting the child on the head, face or ears and hitting or beating the child hard and often. Psychological punishment refers to shouting, yelling or screaming at a child, as well as calling a child offensive names, such as 'dumb' or 'lazy', Violent disciplining includes any of the forms of physical and/or psychological punishment.

106. MONSTAT and UNICEF (2018). Ibid.

107. Government of Montenegro (2019) "Strategy for the Prevention and Protection of Children against Violence (2017–2021)"; Government of Montenegro (2019) "Strategy for the Exercise of the Rights of the Child (2019–2023)".

108. UNICEF data received from the Institute for Social and Child Protection.

109. Ministry of Health of Montenegro (forthcoming), "Guidelines For Health Service Providers Acting With A View To Protecting Children And Adolescents From Violence, Abuse And Neglect".

110. MONSTAT (2019) EU-SILC, Saopštenje_Anketa_o_dohotku_i_uslovima_života_EU-SILC_2019.pdf (monstat.org) http://www.monstat.org/uploads/files/SILC/Diseminaciona%20baza%20-%20Disemination%20data%20base(1).xlsx.

111. MONSTAT (2019) EU-SILC.

112. Annual report of the Ministry of Labour and Social Welfare for 2020.

113. More information can be found at the link: https://www.gov.me/cyr/clanak/dodatak-za-djecu.

114. Material deprivation refers to a state of economic strain and durables, defined as the enforced inability (rather than the choice not to do so) to pay unexpected expenses, afford a one-week annual holiday away from home, a meal involving meat, chicken or fish every second day, the adequate heating of a dwelling, durable goods such as a washing machine, colour television, telephone or car, being confronted with payment arrears (mortgage or rent, utility bills, hire purchase instalments or other loan payments). The material deprivation rate expresses the percentage of persons living in a household that cannot afford at least three of nine items listed above – MONSTAT and UNICEF (2019). "Statistical overview. Material Deprivation".

115. MONSTAT and UNICEF (2019). "Statistical overview. Material Deprivation".

116. Richter et al. (2016), "Advancing Early Childhood Development: from Science to Scale 3". *The Lancet* 2016, paper 3.

117. Information at the link: https://me.propisi.net/usvojene-izmjene-zakona-o-radu-povecanje-minimalne-zarade-sa-222-na-250-eura-od-1-10-2021-godine/.

118. Newborn allowance; child allowance; subsidized meals in preschools; assistance for the education of children and young people with special educational needs; reimbursement of maternity/parental paid leave and maternity/parental paid leave benefits; childbirth allowance and reimbursement of paid leave and paid leave for part-time employment

119. MONSTAT (2018), EU-SILC. The at-risk-of-poverty rate for children aged 0 to 17 is 32%.

120. UNESCO (2021), "Right to pre-primary education: A global study", UNESCO.

121. Ibid.

122. UNESCO (2020), "COVID-19 Education Response Webinar, Ensuring quality of learning and wellbeing for young children in the context of the COVID-19".

123. Fiala and Delamonica (2020), "Children in Poor Households to Soar by up to 86 Million due to COVID-19" available at: https://www.savethechildren.org.uk/blogs/2020/children-in-poor-households-to-soar-by-millions-covid-1.

124. UN Montenegro (2020), "Rapid Social Impact Assessment, The impact of COVID-19 on the general population". A new wave of the research was in its final stages when this publication was in press.

125. UNICEF (2021), "Fact sheet on COVID-19 and children". Available at https://www.unicef.org/coronavirus/regression-and-covid.

126. UNESCO (2020), Ibid.

127. The Institute of Public Health of Montenegro for Radio Free Europe (March 2021), available at https://www.slobodnaevropa.org/a/mmr-vakcine-male-boginje-pandemija-crna-gora-vakcinacija/31164249.html.

128. Roditelji.me Portal (January 2021), available at https://www.roditelji.me/blog/2021/01/27/andrea-tvrdi-da-je-praksa-drugacija-od-teorije-i-poziva-majke-da-budu-odlucne/.

129. NurturingCare.org, COVID-19. Available at: https://nurturing-care.org/topic/covid-19/.

130. Montenegrin Education Information System – MEIS, November, 2020.

131. A regional partnership between UNICEF, Microsoft and the University of Cambridge.

132. UN Montenegro. Ibid. Two-thirds of households with children younger than 18 have a computer/laptop with an internet connection, while only 39% have a tablet with an internet connection that can be used for children to engage in distance learning.

133. Yoshikawa et al., (2020), "Effects of the Global Coronavirus Disease – 2019 Pandemic on Early Childhood Development: Short- and Long-Term Risks and Mitigating Program and Policy Actions", *The Journal of Paediatrics*, published 18 May 2020. DOI: https://doi.org/10.1016/j.jpeds.2020.05.020.

134. ISSP (forthcoming), "The Potential of Additional Investment in Early Childhood Development in Montenegro".

135. The basic package includes: prenatal health care, immunization, micronutrients, parent-oriented programmes, birth registration and one year of preschool education.

136. The enhanced package includes the services defined in the basic package, as well as: access to clean water and air, appropriate sanitation and a 40:1 or lower student/teacher ratio in primary schools, but not social protection.; Early Childhood Development Action Network (2018), "Benchmarking ECD Investments: Options brief": https://www.ecdan.org/assets/investment-benchmark-for-ecd_options-brief_fnl-28-06-2018.pdf.

137. Institute for Strategic Studies and Prognoses, Ibid.