April 2011

ChildreninScotland
every child - every childhood

The early years: what practitioners and policy makers need to know

Early years briefing

BRIEFING PAPER 1: FETAL ALCOHOL HARM

What is fetal alcohol harm?

Fetal alcohol harm is also known as fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorder (FASD). These terms describe a range of birth defects that can result from prenatal exposure to alcohol causing permanent brain and nervous system damage affecting learning, behaviour and life chances.

Estimates are that there are currently over 10,000 children and young people (birth to 18) affected by fetal alcohol harm in Scotland.[1] Dr Maggie Watts, the Scottish Government's FASD coordinator states: "FASD is common. FASD is expensive. FASD is preventable".[2] Scotland's Chief Medical Officer jointly with other UK Chief Medical Officers, has issued clear advice that women who are pregnant or trying to conceive should avoid alcohol.[3] This pre-pregnancy advice from the Chief Medical Officer is included because fetal alcohol harm can occur during the weeks before a pregnancy is confirmed.

Researchers and practitioners around the world agree that FAS is the tip of the iceberg of fetal alcohol harm.[4,5,6] FASD has been 'under the radar' or misunderstood across Scotland and the UK. You do not need to be a health professional to play a constructive and important role in raising awareness, preventing, identifying and/or dealing with the consequences of fetal alcohol harm.

The effects of fetal alcohol harm

Exposure to alcohol at any point during pregnancy creates a risk of lifelong damage to the brain and nervous system of the developing child. Many factors can complicate the identification of FASD. However, decades of laboratory research and animal studies have proved that alcohol alone can cause significant problems.

FASD-affected children often display a variety of learning disabilities and behavioural problems. These primarily are the result of impairment of the brain's 'executive functions', including the ability to plan, learn from experience and control impulses. Children affected might be regarded as being willful or undisciplined when, in fact, they have little control over their behaviour. For example, FASD-affected children may exhibit behaviour problems despite being repeatedly corrected or disciplined. There can be some physical damage associated with FAS, including facial characteristics. However, these usually are not obvious to non-experts and are present in a small minority of the children affected by FASD. Most often, FASD is an invisible birth defect.

Research into the results of fetal alcohol harm for individuals and for society is all but non-existent in Scotland and the UK and limited internationally. [4,5,6] However, there is a growing body of evidence from other nations to back up the logical hypotheses of the serious human, social and economic costs and consequences of fetal alcohol harm.

These costly consequences are already being borne by families and a wide range of public budgets. At the moment, these costs are rarely traced back to the underlying problem of fetal alcohol harm. The price of prevention is small by comparison. The earliest possible identification and intervention may save public funds, as well as enhancing the wellbeing of affected children.

Certainties and risk

Many complex factors are involved, and no test can predict the alcohol-related outcome of an individual pregnancy. For this reason, research has not ascertained safe levels of alcohol intake while pregnant. What is known is that no consumption of alcohol, from conception to delivery, guarantees no fetal alcohol harm.

It is true, of course, that regular heavy drinking is more likely to cause fetal alcohol harm than very occasional or very light consumption. Not all women who drink alcohol (even those who drink large quantities) during pregnancy will give birth to babies harmed by alcohol. There are simply too many influences - for example, genetics, nutrition, metabolism and other substance misuse or health conditions - for anyone to predict which pregnancies will result in fetal alcohol harm.

Identification and management of FASD

With the exception of a formal diagnosis of FAS, the identification and management of care for children and young people who have FASD are not roles limited to medical/health professionals. The children's sector workforce can play a critical role in FASD awareness, although this is a challenge because there is only an emerging body of experience and anecdotal evidence about 'how to tell' and 'what works' from a variety of

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other OECD countries.[6]

The most promising ways of helping people with FASD appear to be behavioural, environmental and relationship-driven interventions by educators, youth workers and other non-health children's sector staff. From childcare providers to school staff members, social workers to youth workers, diverse professionals throughout Scotland can play a pivotal role in identifying children with FASD and then, in taking the next steps to treating them. As with all children, building upon strengths and assets is the best approach, rather than focusing solely on difficulties.

Priorities

The top priority is the **prevention** of fetal alcohol harm. It is urgently important to reach prospective mothers and their partners earlier and more persuasively with accurate FASD facts. The next priority is finding out and **reporting** what is true about the costs and consequences of living with fetal alcohol harm. The final priority is to **identify** and assist those who have FASD. There need to be messages, materials and methods that increase the capacity of our children's workforce to *recognise* when fetal alcohol harm is the cause of (or a contributing factor to) children's and young people's learning difficulties, behaviour and developmental problems – and respond appropriately.

What you can do?

1. **Ask questions about whether, and how, your organisation should become involved in raising awareness, preventing, identifying or otherwise dealing with fetal alcohol harm.** Where does your organisation best fit in this picture? Is fetal alcohol harm alcohol 'on the radar' in your workplace and community? If not you, then who can lead the way on this issue in your area?

2. **Spread the word** – Please share this Children in Scotland briefing with colleagues and discuss it with others in your networks. The more people who are thinking, learning and talking about fetal alcohol harm, the more people can help to bring about change.

3. Think carefully about how you **raise the issue with children, young people, their mothers/fathers/carers and the prospective parents with whom you work.** Support parents in making better choices and encourage them to take a positive steps towards achieving an unharmed child and a happy parenthood.

If you have any comments about this briefing or suggestions about professional practice or strategy, then please contact: Sara Collier at: scollier@childreninscotland.org.uk or on 0131 222 2412.

This document is one in a series of Children in Scotland briefings that highlight issues, research or areas of policy that have a particular impact on children's early years and on the diverse workforce that provides services for this group. This work is supported through grants from Esmee Fairbairn Foundation and the Scottish Government's Child and Maternal Health Division.

References and notes

1. Between 1992 and 2009, there was an average of 56,679 live births in Scotland annually (according to Scottish Government statistics). International research in other OECD countries indicates that a minimum of 1 in 1,000 babies are born with FAS – and that 1 in 100 have FASD. This means that, using international averages, at least 57 babies each year were born in Scotland with FAS and 567 with FASD. By multiplying these annual numbers by 18 years – to cover all children and young people – the number of children with FAS would be over 1000, while the number of children with FASD would total over 10,000 throughout Scotland. [57 per year x 18 years = 1,026, while 567 per year x 18 years = 10,206 FASD-affected children and young people]

The Scottish Government created a fetal alcohol focus within its Child and Maternal Health Division in January 2011. One of its tasks is to produce the first count within Scotland of how many children and young people across Scotland have been affected by FAS or FASD.

Note that the Scottish Government uses the international spelling 'fetal', rather than 'foetal'.

2. Dr Maggie Watts (2011) *Fetal Alcohol Spectrum Disorder: Is it a problem for Scotland?* Paper presented at 'Bruised before birth' Conference, TACT, Edinburgh, March 2011.

3.The Scottish Government (2008) Discussion paper: Setting out our strategic approach to tacking alcohol misuse. Point 70. Pregnancy.
http://www.scotland.gov.uk/Publications/2008/06/16084348/9

4. Public Health Agency of Canada
http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/publications/cp-pc/index-eng.php.

See also: Professor Edward Riley, *The Fetal Brain and Alcohol: Defining Fetal Alcohol Spectrum Disorder (FASD)* Paper presented at 'Bruised before birth' Conference, TACT, Edinburgh, March 2011.

5. *Fetal alcohol spectrum disorders: A guide for healthcare professionals,* 2007, British Medical Association, London.
http://www.bma.org.uk/images/FetalAlcoholSpectrumDisorders_tcm41-158035.pdf.

See also: Health Evidence Network, World Health Organisation (WHO/Europe):
http://www.euro.who.int/en/what-we-do/data-and-evidence/health-evidence-network-hen/publications/evidence-summaries-of-network-members-reports/is-low-dose-alcohol-exposure-during-pregnancy-harmful

6. US Centers for Disease Control and Prevention: http://www.cdc.gov/ncbddd/fasd/index.html

See also: http://fasaware.co.uk/index.php?option=com_content&view=article&id=47&Itemid=28 and www.nofas-uk.org

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BRIEFING PAPER 2: PRECONCEPTION (PRE-PREGNANCY) HEALTH

Why is preconception health important?

The children and young people with whom you work have been shaped by multiple factors, from their family/community background to significant life events. Some of these major influences (such as loving parenting or good nutrition) are positive, while others (such as poverty or child abuse/neglect) are negative.

Preconception health is an often overlooked, but crucial, factor that affects the wellbeing, behaviour, learning and life chances of children and young people. The chain of logic here is straightforward: (1) preconception planning, preparation and health care can make a positive difference in the health of women before pregnancy; (2) the health and wellbeing of the mother at the time of conception is a powerful predictor of the course that the pregnancy will take; (3) what happens during pregnancy determines birth outcomes; and (4) unwelcome birth outcomes, such as birth defects, premature birth and/or very low birth weight, can have lifelong negative consequences for the child's growth and development.

The idea that healthy mothers are far more likely to give birth to healthy babies has been proven by recent research.[1] The promotion of preconception health in girls and women of childbearing age is an excellent way to improve their own health and is especially valuable for those women who are at particular risk of experiencing difficulties during pregnancy.

This is an important topic for Scotland's children's sector workforce for three reasons: (1) better preconception health can be achieved; (2) much of the prevention work could and should be carried out by this workforce as it does not require specialized medical knowledge, training or credentials; and (3) promoting the benefits of good preconception health will improve children's lives, reduce human costs and diminish the pressures on public funds to deal later with problems that could have been prevented.[2]

Three different strategies and audiences for preconception health

Helping women to be as healthy and ready for pregnancy as possible can be achieved, but there is not a 'one size fits all' way to accomplish this goal. The relevant research from the UK, Europe and, especially, North America suggests three broad categories in which Scotland's children's sector workforce can undertake meaningful work.[1,3]

1. Promote the general health and wellbeing of all girls and young women

Encouraging and supporting healthy habits, attitudes and behaviour is a task that requires the active engagement of parents, educators, early years providers and the community. It is compatible with the goals of Scottish child policies, including the Early Years Framework, the Curriculum for Excellence and Equally Well. The latest relevant Scottish survey of the health behaviours of students offers both grounds for hope and a spur to action.[4]

2. Reduce the number of unplanned pregnancies and increase use of family planning services

Secondary school educators, youth workers, sexual health counsellors and others who work with young people and their partners/families have constructive roles to play. Their help is required because Scotland currently has one of the highest rates of unplanned pregnancies in Europe.[5] Contraception is a key part of preconception health because an unplanned pregnancy eliminates the possibility of early pregnancy care.[6] For many pregnant women in Scotland, no meaningful consultation occurs before the first booking appointment with a midwife at 10-12 weeks (by which time a remarkable amount of the child's development has already taken place).

3. Address the specific needs of women with pre-existing health problems

Problem drinking, smoking or drug use (as well as such medical conditions as diabetes, depression heart problems, stress or obesity) are better treated and controlled before conception. Similarly, to cite one of numerous examples, being vaccinated against rubella (German measles) prior to becoming pregnant is a good preventative measure against serious birth defects, but vaccination is not an option during pregnancy. Some medications that are considered safe under normal circumstances can pose health risks to pregnant women.

Maternity services and antenatal care remain absolutely essential to positive birth outcomes and, thereby, to child wellbeing. The Scottish Government has recently reviewed and refreshed its maternity and antenatal policies in a variety of

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helpful and promising ways, including recognition of the significance of pre-pregnancy health.[7]

Next steps that should be taken by Scotland's children's sector workforce

There are approximately 250,000 adults throughout Scotland who work with children and young people.[7] Those who work with young children may also have contact with and influence on the mothers/fathers/carers of these children. Those working with teenagers have a variety of formal and informal opportunities to convey accurate messages about the meaning and value of preconception health to this key audience. There are three priorities for the workforce.

Find out more about preconception health and share what you learn

The references and links provided in this early years briefing offer a wealth of helpful, accessible and enlightening resources about this field.

Remember that the essential elements of preconception health involve a set of clear 'dos and don'ts'

In the months leading up to pregnancy, it is important for women who are likely to become pregnant to:

- stop drinking alcohol, smoking, taking street drugs and being exposed to environmental health hazards[1,3,9]
- check on immunisations, prescription medications, treatment and activities that may need to be changed if/when pregnant[1,]
- start getting to a healthy weight, taking folic acid supplements (to prevent spina bifida and other neural tube disorders), and receiving genetic counselling (if there are concerns).[1,3,9,10]

Initiate or encourage one action in your organisation that will raise awareness, increase understanding or result in better preconception health

These range from holding a 'prospective parents' workshop to helping someone join a health promotion group (e.g. weight reduction or smoking cessation).

Healthy, happy babies, who will have a good chance of growing up to become successful learners, confident individuals, responsible citizens and effective contributors, is a shared goal of virtually all current and future mothers and fathers. Therefore, preconception health and health care is not exclusively a women's issue. Men can be part of the problem or part of the solution. Most importantly, men should be encouraged to participate positively in affecting birth outcomes that can strongly influence child wellbeing.

If you have any comments about this briefing or suggestions about professional practice or strategy, then please contact: Sara Collier at: scollier@childreninscotland.org.uk or on 0131 222 2412.

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2. Mangham L. *et al.* (2009) The cost of preterm birth throughout England and Wales. *Pediatrics* **123** (2), e312-e327.
3. See, for example, the diverse range of articles in two recent special issues of medical journals dealing with preconception health and health care: http://www.mombaby.org/index.php?c=3&s=62&p=481. See also: ACOG Committee on Gynecologic Practice, (2005) Committee Opinion 313: The Importance of Preconception Care in the Continuum of Women's Health Care.
4. Currie, C. *et al.* (2011) *HBSC Scotland National Report: Health Behaviour in School-aged Children*. CAHRU/University of Edinburgh. http://www.education.ed.ac.uk/cahru/publications/reports_downloads/HBSC_National_Report_2010_LowRes.pdf
5. Respect and Responsibility: A Strategic Action Plan for Sexual Health. See:http://www.scotland.gov.uk/topics/health/health/sexualhealth/respect
6. 'Early pregnancy' refers to the weeks/months between conception and the first booking appointment with a midwife to confirm pregnancy and to start maternity services and antenatal care. For ease of reading, only the term 'preconception' will be used, but the relevance of early pregnancy is implicit and undiminished. See, for example, Meyer U. *et al.* (2007) The neurodevelopmental impact of prenatal infections at different times of pregnancy: the earlier, the worse? *Neuroscientist* **13** (3), 241-256.
7. See, for example, the 2011 Refreshed Framework for Maternity Care in Scotland at: http://www.scotland.gov.uk/Publications/2011/02/11122123/0
8. Children in Scotland (2008) *Working it out: developing the children's sector workforce*. Children in Scotland, Edinburgh.
9. On tobacco, see: Action on Smoking and Health (2010) *Fact Sheet: Smoking and Reproduction*. Also see: Royal College of Physicians (2010) *Passive Smoking and Children*. On alcohol, see: British Medical Association (2007) BMA Board of Science, *Fetal alcohol spectrum disorders*, as well as US Centers for Disease Control and Prevention at: http://www.cdc.gov/ncbddd/fasd/index.html
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BRIEFING PAPER 3: THE EUROPEAN COMMISSION'S COMMUNICATION ON EARLY CHILDHOOD EDUCATION AND CARE [COM (2011) 66] (Published February 2011)

What is the Communication?

The Communication outlines the views of the European Commission on the significance of early childhood education and care and its relevance to European economic and social policy. It outlines a direction of travel for national governments and a framework for European collaboration. It was produced by the Commission as a policy statement to influence related activity, and for consideration by the Council of the European Union. The Council consists of relevant ministers from Member States: Tim Loughton, Conservative MP and minister for children and families at Westminster, represented the UK at the Council meeting on 20 May 2011.

Some aspects of education and employment are 'competencies' of the European Union, meaning the EU may pass legislation and spend money on these areas, but historically support for early childhood education and care came under broader equality and employment policies.

By formally adopting the conclusions of the Communication the Council agreed areas to take forward jointly, but there is no legal requirement to enact the recommendations. However it is an important step towards a pan-European agreement on what every government should (and should not) do in the years ahead. It also opens the door to using European funds to implement policies in line with the Communication and adopted conclusions. Thus the recommendations mark a significant development in taking seriously the needs and best interests of young children themselves, rather than as secondary aspects of adult employment policies.

The Communication should encourage an Open Method of Coordination across Europe on early childhood education and care. This is the voluntary development by Member States of national and regional guidelines following endorsement of a broad policy, such as this Communication. Expert networks share and benchmark practice as a source of mutual support and to encourage adherence to policy guidelines. In the past, this has been a way to introduce policy areas that have later been adopted as EU competencies. That could, and should, be the case with early childhood education and care.

A more direct and immediate impact may be through the European Structural Funds allocated to each nation, including Scotland. Both the Communication and the Council conclusions recommend Structural Funds to support early childhood education and care policies. The next round of European Structural Funds will be allocated this autumn, although the exact amount has not yet been determined.

What are the main messages of the Communication and the conclusions?

There have been many in-depth studies of early childhood education and care, most notably *Starting Strong I and II* by the Organisation for Economic Cooperation and Development,[1] and the most extensive EU study to date in *Working for Inclusion: the role of the early years workforce in addressing poverty and promoting social inclusion*.[2]

The Communication and Council conclusions are not detailed outlines of how early childhood education and care should be organised, but recommendations to which Member States should aspire.

They recognise:

- Increased investment is needed, including using "European Structural Funds in line with the goals of the Europe 2020 strategy".
- The benefits of a more integrated approach nationally, regionally and locally, with collaboration of different policy sectors such as education, culture, social affairs, employment, health and justice.
- Providing high quality early childhood education and care is as important as ensuring availability and affordability.
- Equitable access to high quality, inclusive early childhood education and care is particularly important for children from socioeconomically disadvantaged backgrounds or children with disabilities or special educational needs.
- Integration of 'care' and 'education'. In many countries 'care' services have different (often less) funding, and are managed, inspected and staffed separately from young children's education.
- Increased involvement of, and support for, parents.
- Development and professionalisation of the workforce is needed, focusing on developing competencies, qualifications and working conditions; increasing the prestige of the profession; and bringing more men into the sector.
- Identification and support for children with learning difficulties or special educational needs within a mainstream learning environment.
- Promotion of European research and data collection to strengthen evidence for policymaking and programme delivery in early childhood education and care.

Ministers noted the Communication could contribute to the Europe 2020 strategy, in particular the objectives of reducing early school leaving and lifting 20 million people out of risk of poverty and social exclusion.

What is the significance of the Communication and

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conclusions for Scotland?

European Ministers invite Member States to do three things:

- Analyse and evaluate early childhood education and care services locally, regionally and nationally in terms of availability, affordability and quality.
- Ensure measures aimed at providing generalised equitable access to early childhood education and care and reinforcing its quality.
- Invest in early childhood education and care as a long term growth-enhancing measure.

Availability of childcare places

The Communication restates the 2002 Barcelona targets of full day places in formal childcare for at least 90% of children aged between 3 and compulsory school age, and ***at least*** 33% of children under 3. Scotland, counted as part of the UK, has not met either of these, providing ***full day*** formal services for only 5% of children under 3 and 24% of children from 3 to compulsory school age (see Children in Europe[3]).
The Communication adds the important requirement that these childcare places be "of a high quality". Attempts to increase the number of places in Scotland need to take this into account.

Integrated systems

Systems for early childhood education and care are divided between Westminster and devolved governments. In Scotland, care and education are also divided between different systems, including initial education, inspection and funding.

Scotland continues to embed division through qualification, inspection and training systems.

Universal services

The Communication emphasises "generalised equitable access" services, based on research showing that target groups can be difficult to identify accurately; may stigmatise groups in unhelpful ways; and may lead to segregation at later stages of education. This is relevant currently with targeting a predictable option when facing budget cuts. Policy in Scotland must retain the universalist aims of the Scottish Government and CoSLA's Early Years Framework and ensure non-equitable access does not result from attempts to cut budgets.

Structural Funds

The Communication and conclusions specifically mention Structural Funds, inviting Member States to:

"... make efficient use of all relevant EU instruments in the fields of lifelong learning and research, as well as the European Structural Funds in line with the goals of the Europe 2020 strategy, in order to promote the above aims".

Scotland submitted a response to the Europe 2020 strategy in May 2011 with reference to the child poverty strategy, of which the Early Years Framework is part.

European Structural Funds for 2007–2014 have already been allocated in Scotland: the Commission will decide on Structural Funds from 2014 this summer. The strands relevant for early childhood education and care are the European Regional Development Fund (ERDF) and the European Social Fund (ESF): areas of underspend, to be clarified in October 2011, may provide opportunities for investment in Scottish early childhood education and care over the next 2 years under the Council's guidelines.

Longer term policy implications arise from the nature of Structural Funds, which require suitable matching funds from other bodies. Given Structural Funds could potentially support a more holistic view of early childhood education and care, matched funding may become more flexible and follow this European level policy lead.

A report, The Cost of Childcare, *was published by Children in Scotland in February 2011. A more detailed report outlining the state of early childhood education and care will be published later this year. These Scotland-focused reports will aid policymakers to influence the Westminster Government's response and involvement at EU level.*

If you have any comments about this briefing or suggestions about professional practice or strategy, then please contact Sara Collier at scollier@childreninscotland.org.uk or on 0131 222 2412.

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[2]Children in Scotland (2008–2010). *Working for Inclusion: the role of the early years workforce in addressing poverty and promoting social inclusion.* www.childreninscotland.org.uk/wfi
[3]Children in Europe (2011). *Europe's youngest citizens: services and leave provision for under threes.* Issue 20. www.childrenineurope.org

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Changing services, changing lives

Croatia is set to enter the European Union in 2013. As part of an editorial board visit to Zagreb, Children in Europe looked at early years services in this country that has undergone rapid change. With a population below 5 million and an area the size of Scotland, can Croatia offer useful insights for our own planning and policymaking?

All photos: Medveščak kindergarten

Saša Teskeredžić and his son Stjepan arrive at Medveščak kindergarten in Zagreb, which Stjepan has attended since he was a baby. Without this, Saša says, it would be impossible for both he and his wife to work.

Medvešak has six different locations in the city, headed up by principal Mira Kunstek. They offer full time places for 366 children aged from 6 months to compulsory school age at 6 or 7 years old. The main branch has 200 children from around 1 year old: other sites are smaller. One takes the youngest infants, from 6 months to 1 year old.

The original Medveščak kindergarten was founded 35 years ago under the socialist regime, with places for 1000 children on ten sites. When the regime collapsed the number of places plummeted. Now they are increasing again, with new kindergartens being built, reflecting an increase in provision across Zagreb.

Medveščak is one of 60 kindergartens run by the city council. A further 25 private kindergartens receive city funding to help cover costs and subsidise fees for parents. But there are long waiting lists: Medveščak takes less than a third of those who apply every year.

Kunstek first worked in the kindergarten under the socialist regime and returned after a time spent as a government adviser, overseeing change. The opening hours are long – from 6 am until 5 pm throughout the year, only closing for major public holidays – but there is considerable flexibility. Most children arrive between 8 and 9 am and can sometimes stay beyond 5 pm on request.

A new curriculum has been introduced that is child, rather than teacher, focused. Kunstek says it has been well received. It means staff are less concerned with the curriculum than formerly, and more with children and their families. A strong theme has been working in partnership with other family members. "We try to make parents stronger," Kunstek says. "For example sometimes parents don't think a child has a problem, but we invite them into the classroom and they can see for themselves. We always work with parents as a first step."

Inside the kindergarten children can choose among ten different classroom activities, with the older children allowed to move between rooms. These include woodwork with tools including spanners, screwdrivers, hammers and saws. Parents can also pay for additional activities, including an English class for 3- and 4-year-olds and music classes. In recent years there has been considerable focus on using the large outside space more effectively and some classroom activities now take place outside: for example, last year a project involved making electricity from waterfalls. Staff asked children what they wanted and as a result the playground design changed, with the addition of tunnels and areas to dig and excavate. This approach reflects the new freedom Zagreb kindergartens have to innovate and respond to children and parents, says Kunstek. It has also changed the way staff think.

"Teachers now see children with other eyes," she explains. "One day, for example, children in the kindergarten had a map and said they were trying to find treasure. We hid some in the ground for them. Teachers don't just look after the children so they don't break an arm anymore – they ask children what they want to do."

According to Kunstek, it requires a skilled workforce. She has 40 teaching staff, all graduates, and her head of teaching is studying for a Masters degree. Teachers work a 40-hour week, spending 5½ hours each day with the children and the remaining 2½ hours in preparatory work and working with parents and partners. All the sites have access to specialised staff including a speech therapist and special needs teacher, a psychologist and a nurse, and other specialists as required. Many newer kindergartens have disabled access.

The cost is heavily subsidised, with the city paying 80% and parents the remaining 20%: currently this is a flat rate for all parents of 30 euros per month for children under 3 years and 50 euros for older children. This includes four meals a day: breakfast, fruit snack, lunch and afternoon snack. The rate has remained the same for the last 10 years, but plans are being made to introduce a charging policy based on family income and number of children.

Mira Kunstek will address the Children in Europe conference Working with whānau: place, space and connectedness in early childhood *in October. Book now at www.childreninscotland.org.uk/cieten*