

THE  
HEALTH  
PROMOTING  
EARLY  
CHILDHOOD  
SETTING  
PROJECT

Linking families and communities

**Progress Report #1, April 2001,  
Progress Report #2, September 2001  
and  
Progress Report #3, May 2002**

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Linking families and communities

**Progress Report #1, April 2001**

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## EXECUTIVE SUMMARY

The New South Wales Government has demonstrated a continuing interest in and support for children's services. The launch of the Early Childhood Services Policy articulates the objectives and principles that underpin future directions for children's services in New South Wales. The aim of the policy is to *provide a focus on the importance of the early years of life through a system of good quality children's services that are responsive to the needs of children in the context of their families and the communities in which they live* (NSW Government, 2000). Government commitment in this area is evidenced by State Regulations for Children's Services and by supporting research activities to inform policy decisions and to enhance service delivery options.

*The Health Promoting Early Childhood Setting: Linking Families and Communities* represents this research thrust. The project examines ways to build upon relationships that promote health and wellbeing for children, families and for communities through the entry point of early childhood services.

This project complements government policy and other initiatives by providing guidelines and indicators to assist services in determining the nature and applicability of the relationships they have formed with families and their local community and in finding ways to enhance and sustain those relationships.

The project includes survey research, pilot studies and statewide focus groups to develop and test the principles and strategies most appropriate for the development of *Health Promoting Early Childhood Settings* in NSW. The findings will be disseminated through a variety of media including a website, a video, print materials and training programs.

### **Progress Report #1**

This report describes the features and goals of the health promoting early childhood setting project. Five goals are identified for two phases. A review of Phase One goals is given. This includes a review of the literature, and findings from the health promotion survey and pilot studies.

The five underlying principles which guide the project are described in this report. These principles are

1. *Health promotion incorporates a primary health care approach to health and wellbeing and is committed to participation, intersectoral collaboration and equity in service development and delivery.*
2. *Health is a multifaceted construct which is, to an extent, determined by social and environmental factors.*
3. *Early childhood service delivery models need to embrace social goals.*
4. *Quality early childhood settings already reflect health promoting attributes.*
5. *Early childhood services provide appropriate settings for health promotion.*

## **Progress Report #2**

This report describes the second phase of the project. Goals three through to five are described. Components of health promoting early childhood settings were further investigated through the use of pilot studies, focus groups and questionnaires. Key findings from these studies include

- There is a need for greater networking amongst early childhood services.
- Child care centres can see benefits of developing closer ties with health services and vice versa.
- There is a high level of support for networking with community agencies but finding the time to do this is seen to be a major constraint by both sides.
- Parents value opportunities for real participation in decision making about their children and about the directions for the service.
- Some parents are comfortable with minimal participation. These parents value being kept informed of centre and community activities.
- Health promoting activities are most likely to be sustained when they are coordinated by a designated 'facilitator.' The facilitator could be a staff member but the time constraints are difficult to overcome. External facilitators such as parents, management committee members or others bring a unique perspective and can be very valuable in this role - but the expectation of volunteering is not realistic. Some remuneration is recommended for facilitators.
- For the facilitator to be effective, she/he needs to be empowered to make decisions and be supported in implementation processes.

## **Progress Report #3**

This report describes the final phase of the health promoting early childhood research project. Research activities during this phase included:

1. validation of health promoting strategies in rural/ remote areas,
2. validations of strategies for facilitating parent networks through child care settings,
3. validation of the *Healthy Environment Self Assessment Tool* and the *Parent Partnership Self Assessment Tool*,
4. identification of the potential use of a CD rom for training, information dissemination and product development in child care centres.

Findings from these projects indicate the following

- Diverse and multiple communication strategies are effective in facilitating increased family involvement in centre functioning and in disseminating information to parents.
- Childcare centres can effectively facilitate community linkages by identifying existing networks and key contacts in their community.
- Parents report that they are more likely to become involved in centre activities when they know other parents at the centre.
- Staff in childcare centres can facilitate parent networks by establishing vehicles for parent-to parent interactions.
- Self-assessment tools are a useful means for determining areas of improvement.
- Use of CD roms for child care staff was seen as an innovative and appropriate way to communicate information to and from child care staff. The CD rom was valued as a time and labor saving device, especially useful for adaptation and reproduction of communication documents for parents and self-assessment tools.

A description of the promotional materials which are being developed to support the HPECP is included in this report. The materials include a website, currently being trialed at [www.healthychildhood.org](http://www.healthychildhood.org), a video and training manual. A PowerPoint presentation is included in this report. This presentation provides an overview of all facets of the program to date. A bibliography of the international, national and regional literature which informs this project is provided.

## **PRINCIPLES WHICH UNDERLIE THE HEALTH PROMOTING EARLY CHILDHOOD SETTING PROJECT**

This project is designed to enhance the activities of the licensed child care services in NSW, already providing well monitored child care and development services to a large number of families. These services are ideal entry points for community development approaches to family and child wellbeing. The research being undertaken for this project will show how the current infrastructure of child care services can be used to build upon existing supports for families and community wellness by becoming *Health Promoting Settings*.

The principles which underlie the project are described below:

### ***PRINCIPLE 1***

***Health promotion incorporates a primary health care approach to health and wellbeing and is committed to participation, intersectoral collaboration and equity in service development and delivery.***

The health promoting early childhood setting project situates itself within the wider frameworks of Primary Health Care and the *Health for All* movement of the World Health Organisation. These are characterised by the following approaches to service delivery (Macdonald, 2000):

- *Participatory approach*

Health issues are seen to 'belong' to individuals and not to reside entirely within the domain of health professionals. Individuals are encouraged to participate in determining their pathways to health.

- *Intersectoral collaboration*

Health is seen as being impacted upon by a wide range of services and sectors beyond the health field. Underpinning this is a focus on the *social determinants* of health. Many sectors such as housing, employment, education and others need to be involved in the development and determination of health services.

- *Equity*

All individuals and groups have the right to equal access to the building blocks for good health and the right to live in healthy environments.

### ***PRINCIPLE 2***

***Health is a multifaceted construct which is determined by environmental factors.***

The World Health Organisation has adopted the definition of health as *not merely the absence of disease but the total physical, social and emotional wellbeing of individuals and communities*. There is increasing understanding of the links between health and the social, cultural, political, economic, emotional and spiritual environments of individuals and groups. In a seminal work, Wilkinson and Marmot elaborate on the social pathways

to health. In their view, the “importance of ensuring a good environment in early childhood” is one of ten interrelated pathways which define the *social determinants of health* (Wilkinson & Marmot, 1998:7).

This approach contrasts with health or medical concerns which focus on pathologies and “at-risk” conditions. The predomination of the medical model has tended to turn the focus of health programs, including those directed at children, away from the promotion of healthy environments and towards harm minimisation and prevention. The recent work on the social determinants of health provides a timely support for the promotion of a holistic approach to health and well being in a variety of settings, including those which cater to young children and their families.

### **PRINCIPLE 3**

*Early childhood service delivery models need to embrace social goals.*

Early childhood services have moved beyond the delivery of child focused program within the confines of a particular physical setting (See Hayden & Macdonald, 2001). In North America, Europe and elsewhere there is increasing acknowledgement that early childhood institutions serve a myriad of economic, educational and social needs which transcend their original/traditional role of providing substitute care for some children whose parents are in the workforce.

Child care settings are often the first institution that families interact with on a long term basis, and therefore represent the first instance of collaboration between professionals and families. Thus interactions at this level may be critical in determining long-term attitudes and in facilitating social inclusion (versus isolation) of families during vulnerable and sensitive times. In this way, early childhood settings have become a significant facilitator of the knowledge, skill, attitudes and relationships around children, families and communities (Dahlberg, Moss, & Pence, 1999; Hayden, 2000). Increasingly, early childhood services are being accessed by families who are in vulnerable stages - those with very young babies, those who are transient and/or socially isolated, those who are financially stressed and others who have diverse needs due to changing social conditions. This has created a new set of goals and responsibilities for services and staff.

### **PRINCIPLE 4**

*Quality early childhood settings already reflect health promoting attributes.*

Early Childhood settings provide a surprisingly untapped setting for comprehensive health promotion Efforts to implement health promotion in Australia face challenges. The Health Promoting School initiative for example has been criticised for its attention to such matters as getting rid of bullying in school yards and/or to adding a more explicit ‘health’ dimension to the curriculum. The school initiative has made progress in recent years, but it is constrained by some rigid structures and narrow goals which result in a preoccupation with curricula and measurable outcomes.

Early Childhood settings, on the other hand, provide an ideal opportunity to work in partnership in a system which already exhibits an interest in the well-being of the child as its major purpose and which emphasises links with families and, through them, with communities.

Hayden and Macdonald (2000) have reviewed correlations between indicators of quality care as identified in regulations and accreditation documentation in NSW and health promotion. In one study over 85% of the sample of child care centres in NSW scored high on health promotion indicators. An area which was shown to be less developed in early childhood services was the concern by child care staff with the enhancement of social health, specifically in the areas of parental partnership and social cohesion.

### ***PRINCIPLE 5***

***Early childhood services provide appropriate settings for health promotion.***

The potential of creating social supports for NSW families through early childhood settings seems vast and largely untapped. This project will identify strategies for using existing infrastructures to facilitate enhanced partnerships and improved social cohesion. At completion of the project child care centres in NSW will be seen to be making strides towards becoming vehicles whereby good health generating practices take hold; where positive approaches to collaboration with parents and community institutions are modelled and where the roots of networking and trust for social cohesion emerge.

## PROJECT GOALS

The project goals are drawn from the principles described above, from a review of relevant literature, from adaptation of features of the health promoting schools movement and from NSW-based studies previously undertaken by the investigators.

Previous studies revealed high standards of hygiene and safety in child care settings in NSW (based on benchmarks identified in *Health and Safety in Child Care*, Commonwealth, 1998). The studies further revealed that child care centres staff could benefit from increased awareness and support in order to expand their role in the areas of parental partnerships and community linkages (Hayden & Macdonald, 2000, Hayden & Macdonald, 2000a; Hayden, Fraser & De Gioia, 2000).

The goals of the health promoting early childhood setting project are:

- To assist early childhood staff to see beyond the notion of health as preventing the spread of infection and to acknowledge their own role in the overall well being of young children.
- To assist parents' understanding of their health promotion role in the early childhood centre.
- To focus upon successful experiences and identify collaborative approaches to health promotion that can benefit early childhood settings.
- To assist families and staff to work collaboratively to ensure the development and maintenance of the health promoting aspects of early childhood centres.
- To enhance collaboration within the community and to encourage early childhood centres to access resources that will benefit the overall centre functioning.

### **Goals**

#### **PHASE ONE**

- #1** Literature to identify the issues and rationale for a health promoting early childhood setting will be reviewed.
- #2** Research will be undertaken in NSW to assess the current state of health promotion in child care settings.

## **PHASE TWO**

- #3** Research will be undertaken in NSW to identify appropriate strategies for developing and sustaining health promoting early childhood settings.
  
- #4** Information will be disseminated to staff, families, community agents and professionals in order to raise awareness about the benefits and goals of health promoting early childhood settings.
  
- #5** Tools for child care staff to facilitate the implementation of health promoting strategies appropriate for individual settings in NSW will be developed. Tools will be validated and disseminated. Training and other support services to complement use of health promoting tools will be identified.

## GOALS - PHASE ONE

**Literature to identify the issues and rationale for a health promoting early childhood setting will be reviewed.**

### *Summary of the literature*

The literature which supports the health promoting early childhood settings project comes from the fields of Social Welfare, Early Childhood Education, Primary Health Care and Community Development.

The literature provides the rationale for an expanded role of early childhood settings, particularly in the facilitation of social cohesion and community connectedness (Coleman, 1988; Nicholson, Tually & Vimpani, 2000; Minister of Public Works and Government Services Canada, 2000; Krsevan, 2000; Lero, 2000).

Participation, a basic tenet of the Primary Health Care and Health Promotion culture (Macdonald, 2000), is seen as playing a crucial role in constructing healthy environments. Parental partnerships and community cohesion are highlighted as having diverse and long term benefits for children, families and staff in early childhood settings (Shonkoff & Phillips, 2000).

The literature suggests that health promoting early childhood settings can be viewed in term of three major categories of beneficiaries, or target groups, each with its own set of goals.

The target groups for health promoting early childhood settings have been identified as

- children and staff in settings
- families
- communities.

A summary of the rationale for each target group and concomitant goal for the health promoting project is given below.

## **Children and staff in settings**

Health and wellbeing are, to a considerable extent, determined by environments. Institutions can work as agents which facilitate increased control over environments, and thus promote enhanced health and wellbeing in individuals and groups (WHO, 1998).

Healthy environments are important indicators of quality care and contribute to the health and wellbeing of children, staff, families and communities (NSW Health, 2000). In NSW the components which are associated with healthy environments are supported by existing legislation and policies (National Health and Medical Research Council, 1997; National Childcare Accreditation Council, 1994; Centre Based and Mobile Child Care Services Regulation (no.2), 1996).

### **Setting-based goal for the health promoting project:**

*To provide environments which cater to the total health and well being of children and staff within child care settings.*

## **Families**

Partnerships with families, which go beyond parental involvement and which include a role for parents in directing the program and influencing decision making at all levels, contribute to the quality of care and to the health and wellbeing of children and families (Shores, 1998; Swick, Grafwallner, Cockey, Roach, Davidson, Mayor, & Gardner, 1997; Doherty, 2000).

The literature suggests that parental partnership be approached in diverse ways (Butterworth, & Candy, 1998; Hewes, 1998; Ebbeck and Glover, 2000).

A number of strategies to enhance participation of families in creating and sustaining healthy environments are suggested in the literature (Berger, 1996; Caulfield, 1995; Davies, 1997; Doherty, 2000; Endsley, Minish & Zhou, 1993; Mc Bride and Rane, 1996; McBride, 1999).

Strategies for enhancing partnerships include communication to and from parents and joint projects which involve both parents and staff working together (Cox, 1995; Caulfield, 1995; Davies, 1997; Swick, 1992).

### **Family related goal for the health promoting project:**

*To provide services to families with young children which support their decision making in all aspects of their child's health and wellbeing - and to empower them to seek out and develop services to meet family needs.*

## **Communities**

Community connectedness and social cohesion are important contributors to health and wellbeing of children, families and communities (Bullen & Onyx, 1999; Boisioly, Duncan, Hofferth, 1995; Coleman, 1988; Pathways, 2000; Potapchuk, Crocker, Boogaard, & Schechter, 1998; Stansfield, 1999; Cox & Swinbourne, 1999; 11<sup>th</sup> National Health Promotion Conference, 2000; Leeder & Dominello, 1999; Vinson, 1999).

Developing and sustaining intersectoral linkages contributes to social cohesion (Tayler, 1998; Wilkinson, & Marmot, 2000; Barry, 1996; Baum, Bush, Modra, Murray, Palmer, & Potter, 1999; Bergman, 2000; Kenny, 1994; Lomas, 1998).

There is increasing recognition of the benefits of partnerships and collaborations. Early childhood services are well placed to focus upon the critical task of developing and facilitating social relationships, networks and interagency collaborations – and to take an important role in the building of community and civil society (Taylor, Farrell, Whitaker, Golding, Whitehead, Geraghty, Sullivan, Whitta, & Gahan, 2000; Dahlberg, Moss & Pence, 1999; Lero, 2000; Pence, 2000; Hayden & Macdonald, 2001).

Early childhood services provide benefits beyond increasing employment opportunities and beyond providing care and education to any one child or family. They are the corner stone from which effective and supportive communities can be developed and sustained (Dahlberg et al, 1999, Lero, 2000; Hayden and Macdonald, 2001).

### **Community goals for the health promoting project:**

*To improve community wellbeing by assessing the effectiveness of existing resources and by facilitating the development of increased resources for families with young children.*

*To disseminate information, assist with coordination and support liaison, linkages and networks for families and community agencies and services.*

Literature continues to be collected to ensure that the most current research findings direct the program. Some new studies are reflecting a growing recognition that the sustainability of initiatives to support families and communities is correlated to the extent to which families and communities perceive ownership of these initiatives (Johns, Kilpatrick, Falk & Mulford, 2000; Rudo, Achacoso & Perez, 2000). This research is incorporated in the HPEC project. Strategies for health promotion in each child care setting will focus on the need for participation of all stakeholders at both the development and the implementation stages of the program.

**Research will be undertaken in NSW to assess the current state of health promotion in child care settings.**

*Study of hygiene and health promoting attributes of child care centres*

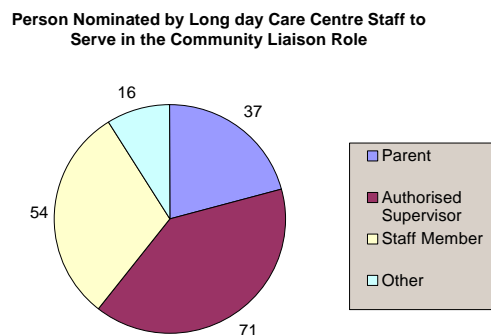
A study was conducted under separate auspices and published in *Australian Journal of Early Childhood*. Observations and interviews were conducted in 40 child care settings in Western Sydney. Child care settings scored high on scales of hygiene (health and safety features) and were rated highly on a number of health promoting activities. Centres scored less well in two areas: parent partnerships and community linkages (see Hayden & Macdonald, 2000).

*Survey on community linkages*

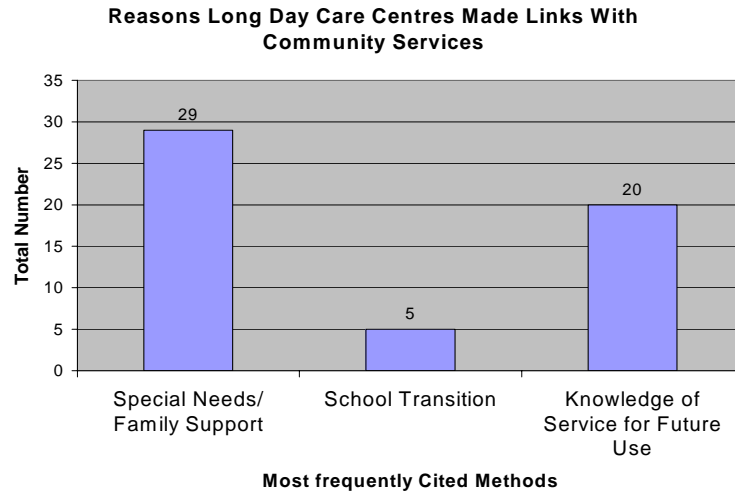
In order to address the areas identified as needing attention, a questionnaire was sent to child care settings in NSW to assess their understanding and commitment towards the development and maintenance of links with community services and organisations (See Appendix Two). Survey responses from 162 centres were collated. Findings are summarised below:

**1. Centres perceive that the role of establishing community linkages is important.**

Slightly more than 50% of respondents identified the authorised supervisor, other staff members, and parents as the appropriate community liaison person. Other suggestions included management committee member, council co-ordinator, and 'everyone' taking on the role.

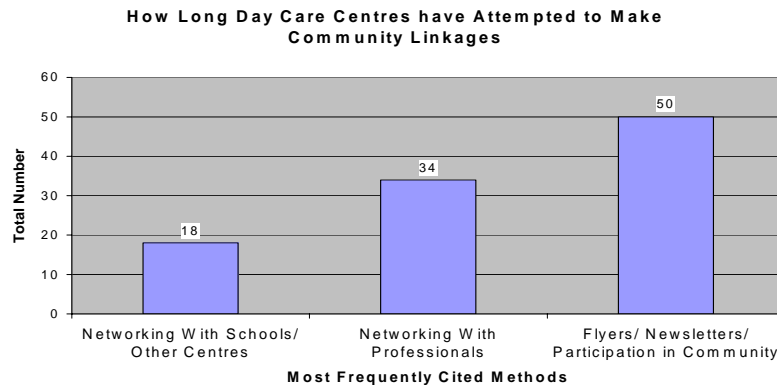


**2. There are many reasons to encourage centre/community linkages.** Centres reported that they were motivated to make linkages for a number of reasons. Chief amongst these were the need for additional resources for children, to fulfil centre and regulatory policies, to fulfil accreditation requirements, because of physical proximity to other agencies, because of contacts through committee members and as a way to increase awareness of their services and enhance their status within the community.



**3. Centres make linkages with community services and agencies in many different ways.**

Centres reported that linkages with community service providers and organisations were made through a range of methods including regular networking with other professionals, collaborating with schools, circulating

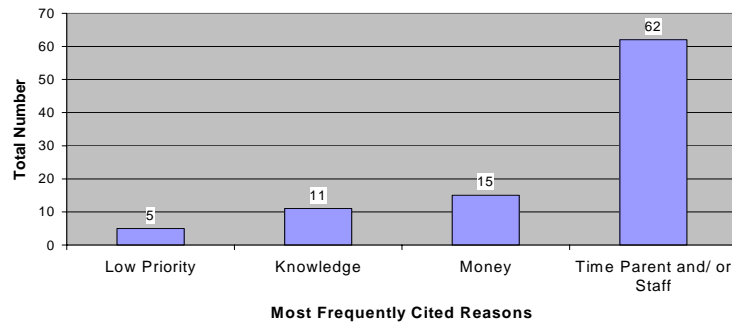


pamphlets, making referrals and linking through parents.

**4. Time is a major constraint for early childhood services in taking on the linking role.**

Constraints to linkages were identified as time, bureaucratic demands, isolation and/or lack of knowledge about the community and about how to make linkages. Other identified constraints included lack of awareness of the benefits which can accrue from ‘linking’, funding constraints and inability to make this a priority in light of other demands on staff.

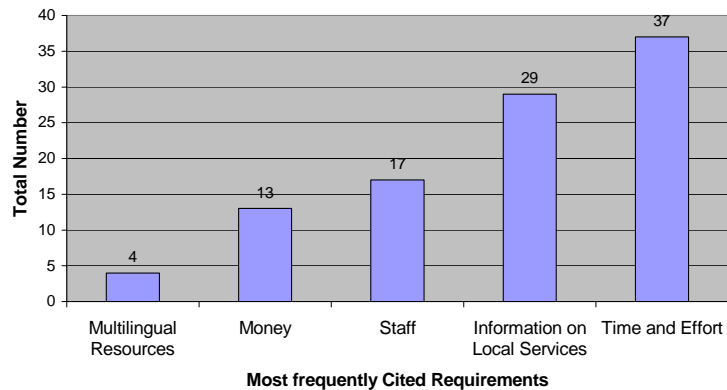
**Constraints to Linking in with Community Services or Agencies Nominated by Long Day Care Centres**



**5. Resources such as increased funds and access to support services would assist in making linkages.**

The majority of respondents identified ‘time’ as the most necessary resource to support linking activities. Other items reported as helping with this role included information about community resources, access to multilingual resources, increased staffing and increased funding.

**Resources and Supports Nominated By Long Day Care Centres as Requirements for Becoming a Community Linking Centre**



End Report #1

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Linking families and communities

**Progress Report #2 September 2001**

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## INTRODUCTION

This report describes the second phase of the project. Goals three through to five are described. Components of health promoting early childhood settings were further investigated through the use of pilot studies, focus groups and questionnaires. Key findings from these studies include

- There is a need for greater networking amongst early childhood services.
- Child care centres can see benefits of developing closer ties with health services and vice versa.
- There is a high level of support for networking with community agencies but finding the time to do this is seen to be a major constraint by both sides.
- Parents value opportunities for real participation in decision making about their children and about the directions for the service.
- Some parents are comfortable with minimal participation. These parents value being kept informed of centre and community activities.
- Health promoting activities are most likely to be sustained when they are coordinated by a designated 'facilitator.' The facilitator could be a staff member but the time constraints are difficult to overcome. External facilitators such as parents, management committee members or others bring a unique perspective and can be very valuable in this role - but the expectation of volunteering is not realistic. Some remuneration is recommended for facilitators.
- For the facilitator to be effective, she/he needs to be empowered to make decisions and be supported in implementation processes.

A description of the promotional materials which are being developed to support the HPECP is included in this report. The materials include a website, currently being trialed at [www.healthychildhood.org](http://www.healthychildhood.org), a video and training manual. A PowerPoint presentation is included in this report. This presentation provides an overview of all facets of the program to date. A bibliography of the international, national and regional literature which informs this project is provided.

## **Stage One Pilot Study: Professional facilitators implement health promoting activities in child care centres.**

In the first stage professional facilitators were sent into child care centres to assess and trial health promoting activities. The two pilot studies were used to trial and assess the following:

- strategies for child care centre staff to facilitate the development of community linkages
- strategies for child care centre staff to facilitate parent partnership in centre related decision making
- strategies for motivating and mobilising staff towards meeting health promotion goals.

### *Methodology*

Professional facilitators were assigned to each pilot centre for a six week period. The facilitators coordinated workshops, organised parent/staff meetings, coordinated the development of a health promoting plan, and assisted parent and staff volunteers to implement the plan.

### *Findings*

Centres increased liaison and linkages with community centres. A number of parents become more closely connected with the service and increased their input into decision making around service development/delivery issues.

Staff reported being pleasantly surprised at the receptivity of the community agencies and at the range of services that agencies could offer to families. Staff reported that they could see benefits from making contact with services and that they supported this activity as an extension of their role in supporting families.

While parents identified benefits of being involved in the pilot activities, the need to overcome time constraints in order to increase the participation rate of parents was identified as a major challenge.

### *Incidental findings*

The smaller service (Centre A) in which the Licensee became very involved in the project appeared more successful in maintaining links in the community. Staff, parents and the participating community agencies reported benefits for all parties and expressed the desire to sustain connections. There were indications that these linkages and others were not dependent on the facilitators' continued support and that they would be maintained beyond the time frame of the pilot study.

Centre B is a community based service, auspiced by local government. Representatives of the auspice organisation were supportive of the centre's involvement in the project but were not actively involved themselves. The Authorised Supervisor was supportive and enthusiastic about the project but she was unable to participate in many of the activities

during the pilot stage. There developed a feeling that linkages could and would be formed on an “as needed” basis, so effort was not put into the development of ongoing, sustainable relationships. Centre B thus, while rating highly in terms of quality care and parent involvement, did not meet criteria for health promotion as a community linking agent by the end of the pilot timeframe.

### **Parent partnership**

Parental participation and partnerships with centres and communities were seen to be constrained because of lack of time and perceived lack of need. Ironically it was found that the most satisfied parents were least likely to take part in activities aimed at service ‘enhancement’. Apparently they see little benefit/need to change the current status quo.

Some strategies for increasing parent awareness, commitment and reciprocity were identified.

These include

- informal parent/staff get togethers
- increasing staff information about parents and using the skills and backgrounds of individual parents to the extent possible
- providing workshops and discussion groups on topics of parent choosing
- increasing media coverage and publicity about centre in order to raise centre status
- allowing parents to experience the benefits of community linkages through the child care centre.

### **Constraints identified**

Constraints to successful sustainable health promoting activities which target parental partnerships and community linkages were identified.

These include

- a perceived lack of time available to director and staff
- a lack of understanding and commitment to the goals of health promotion including lack of immediate outcome
- a lack of understanding about the need to establish and nurture sustainable linkages which extend beyond one event or issue.

There were implications that staff shyness and inexperience in this role constrained staff from taking on lead roles in community liaison activities.

### **Implications from Pilot Study-Stage One**

The findings from Stage One were used to inform the next set of pilot studies. These include:

- Capacity building needs to be incorporated in any health promotion approach. Services are more likely to progress when they address health promotion strategies from starting points which build on current strengths and perceived needs.
- Self- assessment thus is an important entry point for centres taking on a health promotion approach to service delivery.
- Facilitators should be part of the service, or connected in some way. Parents are the most effective recruiters of other parents for participation in events or committees.
- Facilitation needs to focus upon the development of commitment and motivation of staff and parents in order to achieve successful outcomes.
- Suggesting specific tasks in the initial orientation/team building stage is a way of assisting centres to orient themselves towards a health promotion perspective.
- Participation of director and staff is critical for sustained outcomes related to health promoting activities.
- Attitudes about role and responsibilities of early childhood services may constrain progress. Existing attitudes need to be articulated and addressed as a prerequisite to moving towards health promoting child care settings.
- Staff confidence and skills to move into the community need to be enhanced.

### **Stage Two Pilot Study: Community facilitators are used**

Based on findings outlined above, the Draft *Manual and Facilitators' Handbook for Health Promoting Centres* was developed. This manual included strategies to meet the potential needs of diverse settings. The manual and the strategies were trialed through three projects. These were:

- pilot studies in child care centres
- focus groups with parents and community representatives
- interviews and questionnaires for rural and remote settings.

### *Pilot Studies in child care centres*

Four centres were selected to develop and test the *Handbook and Facilitators' Manual for Health Promoting Child Care Centres* and other strategies identified from Phase One. The settings represented diverse service structures. Private, community based and a Church auspiced service were included. One pilot site was a pre-school. All settings were located in communities which scored within the bottom 20% on the NSW scale of socially disadvantaged communities (Vinson, 1999).

Pilot settings recruited their own 'facilitators' who were individuals connected to the centre and also connected to the community in which the centre was situated. Parents, management board members and past parents acted as facilitators.

Facilitators were contracted to the project to implement the activities outlined in the *Draft Handbook and Facilitators' Manual* and to undertake other tasks associated with linking families and communities.

The *Handbook* contained sections on rationale and principles for health promoting settings and listed five strategies for facilitators. Facilitators were asked to implement the strategies in a number of different ways and to comment on the effectiveness and efficiency of meeting the goals for each strategy. A day long workshop was held in Sydney to orient centre directors and facilitators to the goals and processes of the pilot study and to present the '*Handbook and Facilitators Manual for Health Promoting Child Care Centres*'.

The five strategies were:

#### *Strategy 1. Developing a Health Promotion Team.*

The facilitator was asked to develop and co-ordinate a working team which included parents, staff and others. This team took responsibility for developing and implementing the health promoting plan in each centre.

#### *Strategy 2. Raising awareness in the community about what the centre does for children, families and the community.*

The facilitator and health promotion team were asked to develop an information pamphlet for community agencies and others. This pamphlet differed from the traditional information given to parents and other clients of centres. The health promotion pamphlet described the benefits which the centre offers the community and promotes linkages with community agencies and services. The goal was to 'sell' the service to the community.

#### *Strategy 3. Assessing service needs.*

The health promotion team was asked to develop strategies to promote parent participation in all facets of the centre. This involved surveying parents to establish needs and concerns. A second component of this strategy involved the identification of services and supports in the community including accessibility. The hp team was also asked to gather information on services which were needed and not accessible to community families.

*Strategy 4. Assessing community linkages.*

Based on the information gathered, the health promotion team was asked to contact a range of community agencies and initiate linkages where possible. This phase involved investigation of both familiar and unfamiliar supports and services in the community and environs.

*Strategy 5. Developing a Health Promoting Plan.*

Based on information gathered the health promotion team was asked to develop their centrebased *Health Promotion Plan* (HPP). A proforma was recommended which included identification of goals, strategies, outcomes and timeframes for each setting. The HPP focussed on improving parent participation and community linkages. An assessment format for the plan was provided.

Workshops for participants were held throughout the pilot study to guide developments and to share experiences. At the end of the pilot study all participating facilitators, staff and parents statewide were brought together for a second daylong meeting to collate findings and to refine or validate the health promoting strategies. The outcome of this meeting was the development of the *Handbook and Facilitator's Manual for Health Promoting Child Care Settings - Draft #2*. Components of the *Handbook Draft #2* were further validated and/or refined through a series of focus groups held around the state.

**Summary of findings from pilot studies**

The data from the pilot studies were analysed according to the five recommended strategies for health promoting early childhood settings:

- developing a health promoting team
- raising awareness in the community about what the centre does for children, families and for the community
- assessing service needs and facilitating partnerships with parents and between parents
- assessing community linkages
- developing a health promotion plan.

## *1. Developing a health promoting team*

### **Parent participation**

Success with this strategy appeared to be correlated to previous setting practices. When services had been operating within a strong participatory framework, volunteers were more likely to come forward and to remain committed to being part of the hp team.

Settings which had difficulty recruiting volunteers for their health promoting team reported that this role seemed unusual for clients. The skill level of parents was also indicated as a possible constraint to implementing this strategy. It was clear that preliminary and incremental activities need to be offered for settings and services which are not used to working with parents at this level of participation. A self assessment tool and accompanying levels of strategies will be developed to address this issue.

Some parents' reluctance to participate in centre activities of any sort was reported to be linked to a lack of confidence in their ability to contribute. This was prevalent especially amongst parents from non-English speaking backgrounds. Settings identified success with increased participation rates when they used a parent to parent strategy. Those parents with more confidence and/or with a history of involvement in the service were used to liaise and to recruit other parents. This strategy appeared to be effective in nearly all cases.

### **Staff participation**

Staff appeared to be more committed to the success of the team when they were involved from its inception and when they were kept informed of the goals, processes and outcomes. Director commitment to the success of the team was seen to be correlated to staff commitment.

It is imperative that Directors support the concept of the HP team and that staff be involved in all phases of development and implementation.

## *2 Raising awareness in the community about what the centre does for children, families and for the community.*

This strategy was reported to be a challenge. While the development of information sheets and even pamphlets is not unusual for settings, the need to articulate the benefits which the setting offers to the community had rarely been considered. Centres took longer than expected to complete this task, but all reported being pleased with the result and the outcome. Settings reported that the pamphlet provided a useful entry point for discussions with representatives of community services and agencies. The process of investigating the potential and true benefits to the community became self fulfilling. Settings discovered ways that they could improve their relationship with the community through this activity. Interest in the centres was heightened by this product and, in a number of cases new linkages with community services were developed.

There was consensus that assistance with the process would be needed by many settings. Sample pamphlets and/or proformas would be helpful for setting who had little experience in producing this kind of material.

*3. Assessing service needs and facilitating partnerships with parents and between parents.* Most services approached this task by developing a survey of parents and disseminating information between parents. A list of services which were not available to families was generated and referred to the hp team for follow up.

There was some resistance by some parents to this role for early childhood settings. Parents felt that the time and effort involved could mean staff pay less attention to the task of teaching. Comments which reflected this attitude include;

I see the centre's role as one of providing child care only ... (Parent, Centre C).

As long as the centre is caring for and educating our children I don't feel they need to use their time for other things (Parent, Centre B).

Many parents however, indicated that it would be valuable to access information about community resources. The kind of information which was reported as being helpful included information on speech therapy and other remedial services for young children, playgroup and other child care or babysitting services, services for single parents and referrals to recommended health personnel such as GPs and Dentists.

Parents nominated a number of strategies that they believed would facilitate parent knowledge about community services. These strategies include information notices and resource booklets for use by all parents, information sessions with guest speakers on subjects of interest to parents<sup>1</sup>, staff/parent get togethers, newsletters with updated information on services and where/how to access them. The value of providing information in community languages was noted.

#### *4. Assessing community linkages*

The community services and agencies targeted by each early childhood setting differed according to needs identified by the parents. Representatives of community services and agencies were reported to be receptive and appreciative of the approaches by the HP teams and were pleased to develop links. Some comments which reflect reactions from community agency representatives include;

We knew of the centre but we didn't know exactly what it did... (Community Representative, Centre A).

I found it extremely difficult to get any kind of support from the general public and council members in recognising that a centre like this is crucial for women that need a drop-in place, who are in need of community information and don't know where to start looking - (your) child care centre can assist us in our advocacy efforts...and in reaching our potential clientele (Co-ordinator of a Women's Information and Referral Centre, Centre D).

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<sup>1</sup> A majority of parents from all centres identified behaviour management, nutrition and school readiness as preferred workshop topics.

### *5. Developing a health promotion plan*

Goals set by the four pilot centres reflected perceived needs within the centres as well as those in the wider community. Examples of health promoting goals included

To facilitate children to understand and take charge of their own health needs (Centre A).

To disseminate information to and from parents by developing a parent information corner (Centre D).

To liaise with all schools in the area and offer ideas of sustainable linkages (Centre B).

The issue of empowerment was raised. Health promoting teams may not always include the Director of the service. In this case the team needs clear guidelines on decision making processes. This was reflected in the statement by one HP team leader;

I found difficulty in listing goals, strategies and timeline in this plan, it was ultimately the Director's decision as to a plan that was both realistic and sustainable (Parent Facilitator Centre B).

### **Focus groups**

Following the pilot studies focus groups were held to validate and extend data collected. Focus groups consisted of parents, early childhood staff and community stakeholders. Participation in focus group exercises was encouraged from the following groups:

- representatives of non- English speaking families
- participants with Aboriginal or Torres Strait Islander backgrounds
- representatives with an interest in children with special needs
- rural and / or remote community members
- males.

The focus groups were held in communities that had *not* participated in the pilot study in order to extend the validation of findings.

A *Focus Group Leaders Manual*, and other support materials were developed. Facilitators from the targeted communities were recruited. A workshop was held to provide training in focus group techniques. The focus groups consisted of 10 - 12 participants. Each focus group was comprised of parents or representatives from community services and agencies.

Facilitators reported that finding appropriate participants for focus group meetings was not difficult, demonstrating a high level of interest amongst parents and community members in this issue.

## **Findings from focus groups**

### *Parent Participation*

Regular personal contact between parents and staff that allows for the building of trusting relationships was identified as the most important factor in improving parent participation. In building a relationship, staff can also build parent confidence by listening to them and providing a broad range of ways for parents to participate.

As reported in the pilot study parents reinforced that there were feelings of resentment when committees they sat on lacked the authority to make decisions. It was seen to be critical to ensure that parent voices count and that decisions made by committees and elsewhere are carried through.

There must also be respect for those who choose not to participate in overt ways. These parents still appreciate being kept informed of centre activities and of the resources available to them through the centre. They should continue to be given opportunities to participate in all ways but not made to feel uncomfortable if they do not take these up.

Parents reported that they were often unaware of the range of expertise of staff members and/or that centres might facilitate parents with resource and referral services. Parents would appreciate being made aware of these centre attributes.

Some of the constraints noted in regards to increased parent participation and resource and referral service development were:

- that parents do not always live in the area and therefore resource information and opportunities to participate may be limited;
- access to many support services is limited for working parents because of the support agencies hours of operation; and
- developing better relationships with families and the wider community may not be cost neutral.

### *Community Linkages*

Participants stated that personal contact was important in the initial stages of developing a relationship with other services. E-mail was considered to be a viable option for communication but there was concern that child care services do not always have access to the internet.

The provision of a brochure or pamphlet about the centre was reported to be a useful resource for community agencies. Recommended content for the pamphlet included the professional expertise of the qualified staff, the role of early childhood settings in providing holistic family support as well as child centred services and the commitment of early childhood settings to the promotion of health and wellbeing for children, families and communities.

The representatives from community agencies saw value in visiting early childhood settings and identified the need for this to be factored into their job descriptions. The notion of co-location with the early childhood settings was recommended as an ideal way to reinforce linkages, networks and collaborated efforts between community services.

The ability to develop and sustain linkages with community services was clearly seen to need to be a capacity building exercise for early childhood settings. Early childhood services need to approach this activity in incremental stages and to develop infrastructure within the centre before they focus on external relationship building.

It was recommended that early childhood services develop information packages to support different types of linkages. For example whilst two way linkages are beneficial in some circumstances (with schools and health services), there are situations whereby the sharing of information on a regular basis would be sufficient. Community services should be asked to identify which level of linkage is most appropriate for them.

Some of the constraints identified in furthering community partnerships were time and personnel constraints on the part of the community agencies - their hours of operation and availability do not readily coincide with those of centres. The difficulty of centre staff in attending meetings during work hours was identified as a constraint.

One strategy recommended by community representatives was that child care services network among themselves as a first step in developing community linkages. Sharing space was also recommended. Child care centres can offer their premises for community bookings as an entry point for increasing community partnerships.

Findings from the focus groups were analysed. Some gaps in information became clear. These included the generalisability of previous findings to rural and remote areas. A survey was developed to address this gap.

### **Survey for Remote Early Childhood Centres**

Questionnaires and interview schedules for staff, parents and the community were developed to assist extend and validate previous findings (See Appendix Three).

The early childhood settings which participated in this phase of the study are situated in Eden, Orange, Albury, Condobolin and Goodooga. Findings from this component of the study had not been analysed at the time of printing.

### **Summary of Key Findings**

- There is a need for greater networking amongst early childhood services.
- Child care centres can see benefits of developing closer ties with health services and vice versa.
- There is a high level of support for networking with community agencies but finding the time to do this is seen to be a major constraint by both sides.
- Parents value opportunities for real participation in decision making about their children and about the directions for the service.
- Some parents are comfortable with minimal participation. These parents value being kept informed of centre and community activities.
- Health promoting activities are most likely to be sustained when they are coordinated by a designated 'facilitator.' The facilitator could be a staff member but the time constraints are difficult to overcome. External facilitators such as parents, management committee members or others bring a unique perspective and can be very valuable in this role - but the expectation of volunteering is not realistic. Some remuneration is recommended for facilitators.
- For the facilitator to be effective, she/he needs to be empowered to make decisions and be supported in implementation processes.

**Information will be disseminated to staff, families, community agents and professionals to raise awareness of the benefits and goals of health promoting early childhood settings.**

***Dissemination of information to staff, community agents and professionals***

- 600 brochures on *The Health Promoting Early Childhood Setting* were circulated to interested parties at conferences in Australia and abroad.
- 3000 newsletters titled *The Health Promoting Early Childhood Setting. A New Concept for Child Care* were circulated to licensed children's services in NSW.
- An information presentation and seminar was held at Parramatta for an invited group of professionals from a range of service types (see Appendix Two). Participants were invited to join the external management committee for this project and to provide feedback and suggestions in relation to the project, including future directions for collaboration with health and other relevant sectors.

***Publications and public presentations about the program are listed below***

***Presentations***

- Hayden, J. & Fraser, D. & De Gioia, K (2001). *The Health Promoting Early Childhood Program: A New Role for Childcare Service Delivery*. Presentation to External Management Committee for Health Promoting Early Childhood Settings Project. September 21.
- Hayden, J. (2001). Health Promoting Early Childhood Program. *Australian Early Childhood Association International Conference*, Sydney, July 18-21.
- Macdonald, J.J. (2001). Health Promotion in Early Childhood Settings. *International Health Promotion Conference*, Paris, July 15-18
- Fraser, D. & Hayden, J. (2001). Health Promotion In Early Childhood Settings: Looking Beyond The Medical Model.. Symposium presentation with J. Appleton (Qld) at the *Creche and Kindergarten Association International Early Childhood Conference*, Gold Coast, June 25-27.
- Fraser, D. (2001). Creating partnerships in the Care and Education of Young Children. *Creche and Kindergarten Association International Early Childhood Conference*, Gold Coast, June 25-27.
- Hayden, J. (2001). Quality Child Care in Australia-A Health Promoting Approach. Paper presented at the *World Forum on Early Childhood Education*, Athens, April 9-11.
- Hayden, J & Macdonald, J.J (2001). *Health Promoting Early Childhood Centres*. Invited presentation to Queensland Regional Health Services, February, 9.

- Hayden, J. (2000). Health Promotion in Early Childhood Settings: Family and Community Linkages. *Inaugural Conference on the Critical Years*, Queen Elisabeth Centre, Melbourne, Nov 9-11.
- Hayden, J. & Macdonald, J.J. (2000). Linkages and Involvement: The Health Promoting Child Care Setting in NSW. Presentation at the *KU Children's Services Annual Conference*. Sydney, October 19.
- Hayden, J. (2000). Health Promoting Programs for Preschool Aged Children in Group Care. *European Early Childhood Education Research Association*, London, September 3-8.
- Hayden, J. (2000). Health Promotion in Early Childhood Settings. *Health and Inequalities Research Conference*. Canberra, July 28-30.
- Hayden, J. (1999). Community Approaches to Child Health and Education. A Case for Policy Development. Keynote address at the *International Early Childhood Conference*, Queensland Kindergarten Association, Brisbane, June 21
- Hayden, J and Macdonald J.J. (1999) Health Promotion in Early Childhood Settings. Presented at *Developing Social Capital*. 11<sup>th</sup> National Health Promotion Conference, Perth, Australia, May 23-26.
- Hayden, J., Fraser, D., & De Gioia, K. (1999) Early Childhood Education and the Health Promotion Movement. *Australian Research in Early Childhood Education Conference*, Canberra, January.

## Related Publications

- Hayden, J. Fraser, D. & Macdonald, J.J (in press) Early Childhood Settings: Their Role in Health Promotion in *Rattler*.
- Hayden, J. (2001). Early childhood developments in Zimbabwe: A community centred approach to extraordinary circumstances in L. Chan.& E. Mellor (Eds) *International Developments in Early Childhood*. New York: Peter Lang.
- Hayden, J., Macdonald, J.J. & Fraser, D. (2001). Health promotion, social determinants and the role of the early childhood setting. *Bedrock* , 6 (2).
- Hayden, J. & Macdonald, J.J. (2001). Community centred child care - A new answer to “Who benefits?” *Australian Research in Early Childhood* 8 (1) 33-40.
- Hayden, J. & Macdonald, J.J. (2000). The health promoting child care centre. *Australian Journal of Early Childhood*, (25) 32-40.
- Hayden, J. (2000). The view from Australia. Keynote address published in Advancing early childhood care and education in Canada, Britain and Australia: Exchanging knowledge and strategies across borders in *Conference Proceedings of the International Symposium on Child Care*, Child Care Resource and Research Unit, Centre for Urban and Community Studies, University of Toronto, Metro Hall, Toronto, November 17.
- Hayden, J & Macdonald, J.J. (1999) Early Childhood Education and Health Promotion. Keynote address published in *Conference Proceedings of the International Conference on Early Childhood Education, Kindergarten Association of Queensland*, Brisbane, June 9-12.

**Tools for child-care staff to facilitate the implementation of health promoting strategies appropriate for individual settings in NSW will be developed. Tools will be validated and disseminated. Training and other support services to complement use of health promoting tools will be identified.**

### **Website**

The website has been designed to provide a range of relevant information. Initial log-on provides the user with an overview of the program and the range of links allows those wanting more information to either read full text articles or access a number of hyper-linked addresses including DoCS, other early childhood sites, the World Health Organisation and others. For those seeking a personal connection, contact details are provided for members of the HPECP team. The website address is <http://www.healthychildhood.org>.

### **Video**

The video contains messages for staff, families and other community service agents. Manuals to assist with discussion groups are being developed for each of these audiences. The key message of the video is that early childhood settings are health promoting. They can (and do) undertake a range of activities that support the wellbeing of children, families and ultimately the community.

The video supports the health promoting training manual but serves also a stand-alone product that can be used by community agents and/ or in public venues for information of families and others.

### **Health Promoting Training Manual**

The *Handbook and Facilitators' Manual for Health Promoting Child Care Centres* has undergone two major drafts. It has been reviewed and validated through several processes. The findings from questionnaires to rural and remote areas will contribute to the third draft of the manual. Additional feedback from interested parties including parents, early childhood staff and community representatives will be sought before the final draft is sent to press.

## Conclusion

The *Health Promoting Early Childhood Setting Project* is showing signs of broad acceptance and support throughout NSW and further afield. Research findings indicate that raised awareness will contribute to positive attitudes towards health promotion in child care centres by staff, parents and community representative. Further, the provision of clear guidelines and strategies have been shown to enhance the ability of child care services to make sustainable, mutually beneficial links with families and with community 'players'.

The enthusiastic reception of the underlying principles and objectives of the health promoting early childhood settings project by varied audiences at both local and international presentations indicates a high level of support outside of the early childhood sector. Continuing efforts to liaise with the health sector and others and to disseminate project information in a range of public and professional forums will continue to further develop this support.

THE  
HEALTH  
PROMOTING  
EARLY  
CHILDHOOD  
SETTING  
PROJECT

Linking families and communities

**Progress Report #3 May 2002**

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## Introduction

This report describes the final phase of the health promoting early childhood research project. Research activities during this phase included:

1. validation of health promoting strategies in rural/ remote areas,
2. validations of strategies for facilitating parent networks through child care settings,
3. validation of the *Healthy Environment Self Assessment Tool* and the *Parent Partnership Self Assessment Tool*,
4. identification of the potential use of a CD rom for training, information dissemination and product development in child care centres.

Findings from these projects indicate the following

- Diverse and multiple communication strategies are effective in facilitating increased family involvement in centre functioning and in disseminating information to parents.
- Childcare centres can effectively facilitate community linkages by identifying existing networks and key contacts in their community.
- Parents report that they are more likely to become involved in centre activities when they know other parents at the centre.
- Staff in childcare centres can facilitate parent networks by establishing vehicles for parent-to parent interactions.
- Self-assessment tools are a useful means for determining areas of improvement.
- Use of CD roms for child care staff was seen as an innovative and appropriate way to communicate information to and from child care staff. The CD rom was valued as a time and labor saving device, especially useful for adaptation and reproduction of communication documents for parents and self-assessment tools.

## **Validation of the health-promoting program in rural/ remote settings**

A questionnaire was developed to assess the validity of the health-promoting program with services and families in rural and remote communities of New South Wales.

### **Methodology**

Questionnaires were developed for parents, staff and associated community representatives in early childhood settings in rural and remote areas of NSW. The participating childcare centres were located in the following regions:

- Albury
- Condoblin
- Eden
- Goodoonga
- Orange

Directors of participating centres distributed questionnaires to parents, staff and representatives of the community agencies associated with their centre. The questionnaires addressed current practices and sought ideas for enhanced parent partnerships and community linkages.

### **Findings**

Findings are categorized as follows:

- communication strategies,
- implementation of the Health Promotion Program,
- linkages
- comparison with findings from metropolitan centres.

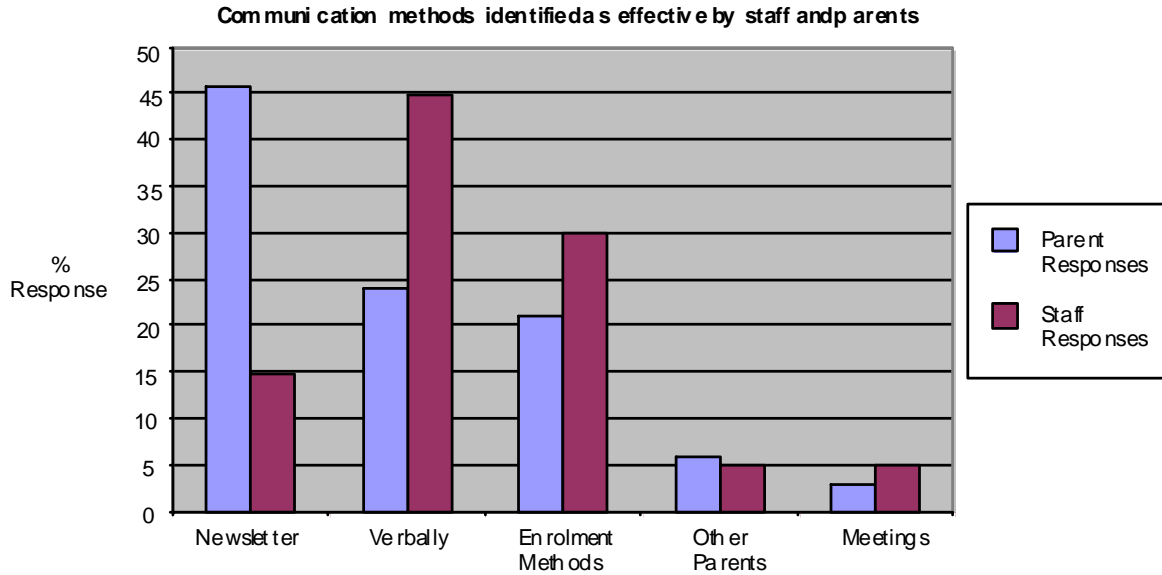
#### *Communication strategies in rural/remote settings*

1. Parents and staff differ on the value they place on particular communication strategies. Staff undervalues some of their own communication strategies. Use of centre newsletters as a way to disseminate information is particularly undervalued by child care staff.

2. Verbal communication (face to face or by telephone) is seen by both parents and staff as an effective communication strategy.

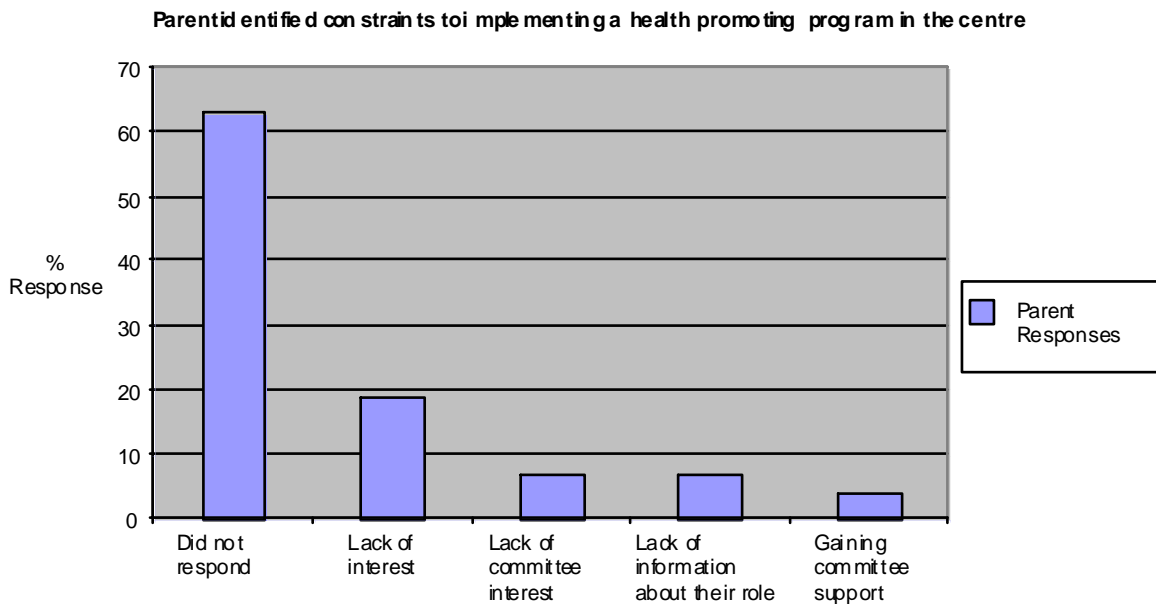
3. Using a number of different methods increases participation of parents in centre activities.

4. Parents are more like to feel involved when they have contributed at all phases of the activity (including planning).



*Implementation of the health-promoting program*

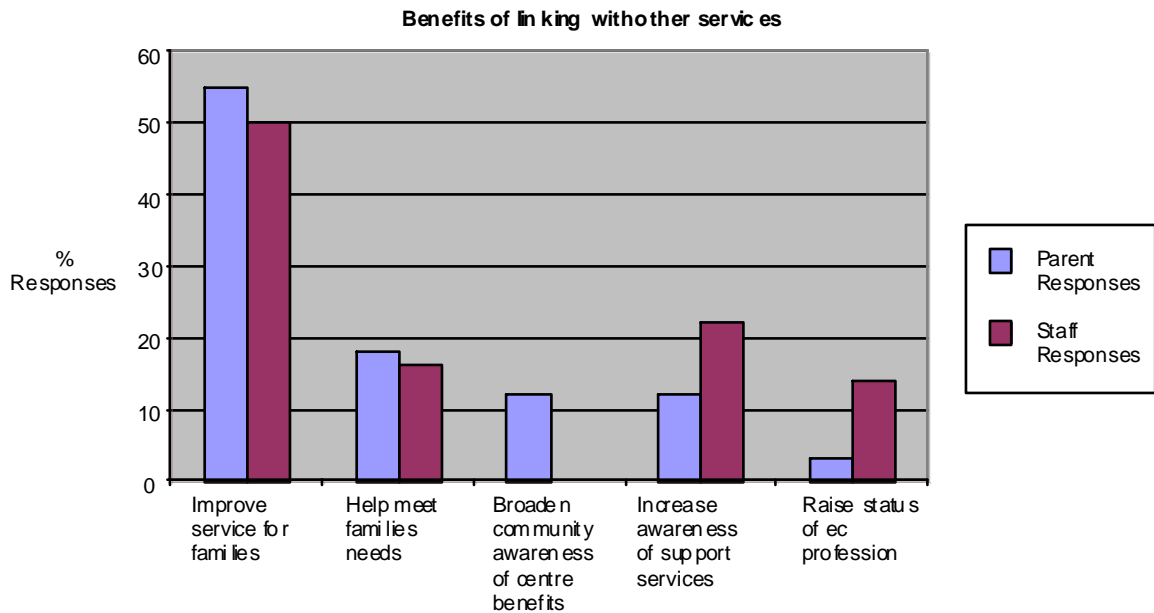
1. Parents did not identify constraints in implementing a health-promoting program in their centre. The majority of parents (63%) left the question which states, "What constraints or problems might occur in implementing a health promoting program in this centre" (The health promoting program had been described to respondents).
2. Parents reported that information about the program, and specifically about any new expectations for parents, is an important element in securing commitment to the program.



*Linkages with community*

1. Parents and staff can identify benefits of linking with the local community. Both parents and child care staff identified *improving services for children and families* as the main benefit for linking the child care centre to the community.

Staff did not identify *raising the profile of the centre* as an important benefit arising from improved community linkages. Community agencies did identify this as an important goal for childcare centres.



Both staff and parents suggested that the development and sustainability of successful links with community services be included in the job description of a staff person/s.

Comments include

Try to incorporate planning into the [staff person’s] schedule so that it is not just an added task. (Parent, Centre A).

For staff to be encouraged to contact services instead of it being expected to be the Director’s job. (Staff, Centre E).

2. Developing linkages needs to build upon current capacities.

Community agencies identified the importance of working with networks which already exist or with key people in rural/ remote communities to raise the profile of the program.

Community agencies reported that centres had been effective establishing community linkages. One agency representative stated

“I believe that many child care centres have already made very good links with community agencies.” (linked to Centre C)

*Comparison of findings between rural/remote centres and centres in metropolitan areas*  
Response about parental partnership and community linkages do not differ substantially between the services in remote and rural areas and those in metropolitan areas.

## Developing Networks between Staff and Parents and among Parents

Developing parent partnerships and facilitating parent networks had been identified as gaps in health promoting activities in childcare centres in NSW (Hayden & Macdonald, 2000). Strategies to address these gaps were developed in the pilot studies in several child care centres throughout NSW. *The Draft Health Promoting Manual and the Draft Hand Book for Facilitators* were developed from these studies. Focus groups and a post-pilot case study were undertaken to ensure generalisability of the strategies. The post pilot case study took part during this phase of the project.

### Methodology

A facilitator was recruited to oversee implementation of *The Draft Health Promoting Manual and the Draft Hand Book for Facilitators* in one area in Northern, rural NSW. The facilitator worked with the childcare staff to trial and assess the strategies identified in these documents.

### Findings

Findings from the post-pilot study were used to revise and/or re-focus aspects of the *Health Promoting Manual and Handbook*. These included

#### *Motivations for parent participation in centre activities*

Staff in the centre reported being surprised at some of the parent responses about why they did or did not participate in centre activities. The exercise reiterates the importance of staff asking appropriate questions to uncover motivations and concerns of parents.

Some of the reasons for participation which surprised staff include:

- I meet other families (Parent 1 and staff person 2, Centre A).
- I find out more about my child's activities (Parent 3 and staff person 1, Centre A).
- I have an opportunity for informal chats with staff (Parent 4 and staff person 1, Centre A).
- My child persuaded me to be involved. (Parent 5)
- I feel a pressure to participate, even when it is not convenient for me (Parent 6, Centre A).

#### Other findings include

Reminders about activities and events are very helpful. When staff communicate personally about the event, I feel more encouraged to get involved (Parent 8, Centre A).

Reasons for not being involved include general busyness of parents, pressures from work on parents and this statement.

- I do not feel comfortable because I don't know anyone else. I guess its shyness...(Parent 7, Centre A).

#### *Including parents in all phases of centre activities*

The facilitator trialed this strategy by organizing a morning tea for centre families and guests. A system was devised whereby each parent was asked to take responsibility for inviting another parent. Parents were involved in all aspects of the organisation of the event. This strategy was highly appreciated by parents. They stated that they felt welcomed and involved in the event - even when they could not actually attend the tea.

The outcomes from this activity included

- an increased number of parent attending compared to previous years
- two social family networks were formed on the day with parents extending invitations to each other's homes.

- staff noticed parents engaged in conversation a week after the event
- parents have asked for more social activities to be held throughout the year.

Comments included

As I don't know many people in the centre and find it difficult to strike up conversations, [this] gave me an easy way to be involved and meet people (Parent 16, Centre A).

I felt more comfortable coming [to the centre] because I had something to do and I could watch what was going on (Parent 9, Centre A).

## Validation of Self-assessment Tools

Self-assessment tools were developed as part of the Healthy Promoting Program. In earlier phases of the project it was determined that self assessment tools motivate staff by ensuring that they follow strategies targeted at their level of capacity. The tools were designed in a generic way with recommendations to adapt for diverse needs of each individual setting. The tools which have been included in the *Health Promoting Manual* have been revised based on the validation findings described below.

### **Validation of the *Healthy Environment Self Assessment Tool***

The *Healthy Environment Self-Assessment Tool* had been developed by Hayden and Macdonald in a previous study (See Hayden & Macdonald, 2000). The tool is based on national standards for health and safety practices in child care settings as outlined in *Staying Healthy in Child Care – Reducing the Spread of Infectious Diseases* (NHMRC, 2000). This resource is available in every child care centre in NSW. This tool was validated for inclusion into the *Health Promoting Early Childhood* program.

### *Methodology*

Three long day care centres within the Sydney metropolitan participated in the validation process. The centres were provided with the tool and given specific questionnaires about its use and effectiveness. Some follow up phone calls were made to clarify points raised

### *Findings*

The average time taken to complete this assessment tool was 28 minutes. This was deemed to be an appropriate time frame for such a tool.

The scoring system was seen to be complicated. This was changed in the final version. Directors reported that repetitive use of the tool at regular intervals would be useful.

It was suggested that staff in each room be given the opportunity to assess their own room - and that several staff in each room use the tool over a long period of time (up to one month) as a guide as well as an assessment tool. These suggestions were added to the instructions for use of the tool.

Validators of the tool suggested enhanced uses for the tool. These included

- share with staff to improve low scoring areas
- share with manager and/or licensee
- share with parents to gain their assistance in meeting health hygiene goals
- show improvements on health and hygiene issues over time
- assess changes in hygiene needs over time
- train new staff
- analyse the incidence of hygiene and health related issues in centres.

These uses were incorporated into the appropriate sections of the *Health Promoting Manual*.

### **Validation of the Parent Partnership Assessment Tool**

The parent partnership tool was designed during the pilot stage of the research project. This tool contains a section to be filled in by parents and a parallel section to be filled in

by staff members. The tool allows for a comparison on perceptions by these two groups. Accompanying documents highlight ways to use the comparisons to open up discussion between staff and parents.

### *Methodology*

After development the tool was trialed by groups who had not been targeted during the pilot/development stages. The trial participants were from non-English speaking backgrounds; parents of children with additional needs; and/or Aboriginal / Torres Strait Islanders users of child care services.

### *Findings*

The average time taken to complete this assessment tool was 11 minutes. This was deemed to be an appropriate timeframe.

Concerns were raised about the context of the questions and use of jargon for Aboriginal and non-English speaking background families. Some changes were made to the assessment tool and a statement was added that the user of the tool (usually the Director) must test and adapt the questions to their clients and the community.

Respondents identified increased uses for the tool as follows:

- share with staff to improve parent partnerships
- share with manager and/or licensee to lobby for changed policies or increased resources
- share with parents to facilitate enhanced partnerships
- use to assess improvements on issues over time
- use to assess changes in partnership practices over time
- use as a training tool for new staff .

### **Need for translation**

One significant finding from the research into the development and use of self assessment tools is that translation into home languages of parents will significantly improve the return rate of family assessment questionnaires and the value of the tool as a guide for enhanced service delivery.

## The CD rom

CD roms (CDs) have been recognised as an effective and inexpensive means of disseminating information. It has been suggested that 90% of Australian homes have access to computers and that growing numbers of individuals identify computers as their main source of information and communication.

The *Health Promoting Early Childhood Program* includes a CD component for use by staff and (potentially) parents.

The CD included in the Health Promoting resource package contains all aspects of the program. The entire manual is accessible on the CD. The video is also on the CD and can be screened on any computer. The entire website which supports the health promoting program with extra information for staff and parents is included on the CD. Most significantly, the CD contains an interactive component. Readers can fill in surveys and send through to the health promoting research team for compilation and comments. The CD - and all components - can be updated and disseminated at low cost.

Focus groups were held with 23 staff from a variety of child care settings to identify the uses and preferred format for the CD. All respondents were receptive and positive about the use of the CD. Participants agreed that self-assessment tools are most effective when they can be (easily) adapted to suit individual characteristics. The CD was appreciated as a vehicle which enables the adaptation of tools and other sample documents from the Health Promoting Early Childhood Program. Staff can make individual revisions, changes and additions to all health promoting documents prior to printing. Alternatively, documents can be emailed to parents and community agencies directly from the CD. Recommendations for content and user-friendliness were incorporated into the development of the *Health Promoting CD*.

## Conclusion: The Products

This is the final report of the Health Promoting Early Childhood Setting Project. The project has been funded by the NSW Department of Community Services since 2001.

The products associated with the program were completed in June 2002. These include

1. *The Health Promoting Manual for Early Childhood Services in NSW*
2. A Video: *Episode 1: Linking Families And Communities*
3. *The Health Promoting CD Rom*
4. The Health Promoting Website: [www.healthychildhood.org](http://www.healthychildhood.org)
5. The Health Promotion Newsletter: *Healthy Childhood*

### 1. The health promoting manual

The manual serves three purposes:

1. It provides information about health promotion in early childhood settings.
2. It provides assessment tools so that centres can measure their own progress towards meeting health promotion goals.
3. It describes strategies to enhance health promotion in early childhood settings in New South Wales.

The manual is divided into 7 sections. Each section is self-explanatory and can be implemented independently of all others.

#### *Self-assessment tools*

Self-assessment is one of the most influential means for making changes, improvements and enhancing service delivery. Thus, the main sections of the manual include tools for centres to measure how health promoting they are currently. The self-assessment tools are most effective when they involve all staff, parents (where appropriate) and others. It has been shown that individuals who participate in assessment exercises and who have a chance to review and discuss the findings are likely to become involved and committed to change and improvement.

### 2. The health promoting video

The health promoting video series provides a demonstration of what a *health promoting early childhood centre* looks like. In *Episode One: Linking Families and Communities* the focus is on the way that early childhood services support families and develop linkages and networking within the community.

#### *The story*

In the video we see a disinterested reporter who is unhappy about being assigned to cover activities at the local childcare centre. Finally he decides that a story about “babysitting while parents work” might have a bit of interest for the community. He agrees to put together 400 words for the local paper. The reporter visits the childcare centre where he is slightly overwhelmed by the activity. As he interviews the director and teacher we see his attitudes changing. He becomes convinced that the childcare centre is addressing a wide

variety of family needs. In the end he insists on a front-page spread to emphasise the services which the childcare centre provides to the community.

### ***Messages portrayed in the video***

Besides focusing on the positive *health promoting* aspects of child care centres, the video addresses some misconceptions about the use of centres. Some of the messages portrayed include:

- 1) Early childhood settings promote well being for families and facilitate the development of community cohesiveness/ community health.
- 2) Staff in early childhood settings are trained professionals.
- 3) Early childhood settings are not 'unhealthy' – good hygiene practices are followed.
- 4) Early childhood settings do much more than focus on child and setting based goals. They
  - build networks amongst parents and facilitate parent-mentoring processes (parents helping parents)
  - cater to a wide representation of families in each community
  - represent a microcosm of society. Here children learn to become caring and helpful citizens
  - provide opportunities for networks and the formation of long life friendships – for parents and for children
  - help facilitate the transition to school for children, parents and school teachers
  - provides resources and referrals for parents.

### ***Target audiences and support documents***

The target audiences for the video series are

- 1) staff in child care centres and/or potential staff (students)
- 2) parents who attend child care centres and parents who are considering using child care centres
- 3) representatives from health and other community services involved with service delivery to children and families who use child care centres or, who are considering using childcare centres.

Suggestions on how to use the video and discussion questions are available.

### **3. The health promoting website ([www.healthychildhood.org](http://www.healthychildhood.org))**

This website contains tips and suggestions for staff, information for parents and research reports and articles which have been written about the health promotion program.

### **4. The health promoting CD rom**

The CD rom contains the complete text of the manual, including sample documents, which can be customized for each centre. The video and the website are included on the CD rom.

### **5. The health promoting newsletter- *Healthy Childhood***

The newsletter is a vehicle for sharing research findings, disseminating relevant and current information and stimulating dialogue and collaboration between professionals with interests in the well being of children and families. Plans to develop a monthly newsletter are underway. (The newsletter is available on the website)

## APPENDICES

Summary of Principles, goals and features of the health promoting early childhood setting program

## **APPENDIX ONE**

### **SUMMARY OF PRINCIPLES, GOALS AND FEATURES OF THE HEALTH PROMOTING EARLYCHILDHOOD PROGRAM**

#### **Principles behind the development of early childhood as health promoting settings**

1. Health promotion incorporates a primary health care approach to health and wellbeing and is committed to participation, intersectoral collaboration and equity in service development and delivery.
2. Health is a multifaceted construct which is, to an extent, determined by environmental factors.
3. Early childhood service delivery models need to embrace social goals.
4. Quality early childhood settings already reflect health promoting attributes.
5. Early childhood services provide appropriate settings for health promotion.

#### **Goals of the health promoting early childhood program**

1. To assist early childhood staff to see beyond the notion of health as preventing the spread of infection and to acknowledge their own role in the overall well being of young children.
2. To assist parents' understanding of their health promotion role in the early childhood centre.
3. To focus upon successful experiences and identify collaborative approaches to health promotion that can benefit early childhood settings.
4. To assist families and staff to work collaboratively to ensure the development and maintenance of the health promoting aspects of early childhood centres.
5. To enhance collaboration within the community and to encourage early childhood centres to access resources that will benefit the overall centre functioning.

#### **Features for early childhood health promoting settings**

1. To provide a safe, healthy environment.
2. To provide resource and referral services which can increase access to health and other community services.
3. To ensure full participation of families and community members in setting activities .
4. To engage health, education and community leaders in setting activities.
5. To improve the health of the community.