Health promotion: A new leadership role for early childhood professionals

Jacqueline Hayden & John J. Macdonald
University of Western Sydney

This article argues that there is a need to articulate the link between concepts of health promotion and the early childhood tradition of quality care, and to establish child care centres as settings for health promotion. The World Health Organisation notion of health promotion is used to describe an approach to health which includes not only the absence of disease but also the facilitation of practices and the maintenance of environments which promote the wellbeing of children, families, staff, and community. The authors contrast the literature about health in child care settings with their findings from a recent study of health related practices in centres in New South Wales. The review of the literature revealed predominantly cautionary information about child care usage, focusing on ways to minimise the spread of infectious diseases. In contrast, the research findings showed that, except for two areas (parent participation and community collaboration), health promoting activities are common and widespread within child care centres. The authors conclude that, through dissemination of appropriate information about quality child care, and with a change in attitude by health professionals, child care centres can become significant players—indeed leaders—in the area of health promotion.

Early childhood education in the new millennium

The role of early childhood education is changing. Early childhood education in the new millennium is now seen to incorporate a definition of service and quality that goes beyond child-focused activities within the physical setting. Analysts are referring to this as the fourth discourse of early childhood education. Traditionally, early childhood services were defined by three discourses: services to support female workforce participation (the first discourse); services which provide compensatory experiences for families and children who have special needs (the second discourse); and/or school readiness programs which provide socialisation and early literacy/numeracy experiences to preschool-aged children (the third discourse) (Lcro, 2000; Pence & Bennet, 2000; Hayden, 2000).

The emergence of a fourth discourse acknowledges that early childhood services serve myriad economic, educational and social needs (Goodfellow, in press). In the new millennium a majority of families are making use of early childhood services for very young children. Early childhood settings are increasingly likely to be the first institution that families interact with on a long-term basis, and the first instance of collaboration between professionals and families. In this way early childhood settings have become a significant facilitator of knowledge, skill, attitudes, and relationships around children (Dahlberg, Moss, & Pence, 1999; Hayden, 2000). Thus the fourth discourse represents a changed focus for early childhood settings—from being child-centred to being family and community-centred (McBride, 1999; Hayden, 2000a).

Indicators of quality in child care

In keeping with the fourth (family and community oriented) discourse, quality care indicators are seen to incorporate two sets of variables. The first refers to the traditional ‘micro’ items which are present in the classroom/centre. The second set of quality variables refer to macro or contextual influences on service delivery and the development of social capital and civil society.

Thus assessing child care service delivery also calls upon two distinct approaches. The first approach assesses child-centred outcomes and child-focused
practices. Here, quality is related to variables associated with the development and implementation of the program/curriculum and the factors associated with care and education of children within the physical setting (see Doherty-Derkowski, 1994; Hayden 1996).

The second (macro) approach for assessing quality focuses on relationships and linkages. This is reflected in practices which are culturally sensitive and which encourage family involvement and community participation. Factors associated with this second approach include the extent to which services perform in the following areas:

- respect for language, culture, and religion of families in the community;
- two-way communication between home and centre;
- collaboration with community organisations and other linkages;
- empowerment of parents (Doherty-Derkowski, 1994; Lero, 1999; McBride, 1999; Moss, 1995).

There is a significant similarity between these macro indicators of quality care and components of health promotion.

**What is health promotion?**

In the context of societies with high infant mortality, a focus on children's health in preventing and curing illness is understandable. But with the reduction in infant mortality in many societies, there is less excuse for thinking of health in the narrow biological perspective of what 'needs fixing'. There is an imperative to take on board the definition of health from the World Health Organisation (WHO). WHO holds that health means not only the absence of disease, but the total physical, psychological, and emotional wellbeing of individuals and communities (WHO, 1984).

The health promotion movement is part of this wider shift in health thinking and policy. It incorporates a move away from a preoccupation with disease, to a broader vision which stresses the creation and maintenance of health and wellbeing in different contexts. Health promotion challenges the position that health is exclusively the domain of medical practitioners and acknowledges that other factors in the environment play a significant role in determining our health (Wilkinson & Marmot, 1989).

Tones, Tilford and Robinson define health promotion as:

> ...Any combination of education and related legal, fiscal and organisational interventions designed to facilitate the achievement of health and the prevention of disease (Tones et al., 1990, p.4).

Thus health is viewed as a complex dynamic reality rooted in many social and environmental as well as physical and structural factors (Wisner, 1988).

Within this broad interpretation of health promotion, there is an emphasis on partnerships and collaboration. Agencies and professionals involved in the building and sustaining of health need to work side-by-side with those responsible for the development and maintenance of environments which foster health. Hence, notions of collaboration and participation are intrinsic to the concept of health promotion (Macdonald, 1996). Professionals and individuals/families are seen to work together to create and sustain environments conducive to health. Partnerships are also needed between different professionals; for example, between town planners and health service professionals and between educators and health service professionals. WHO describes this notion of collaboration as follows:

> Health promotion has come to represent a unifying concept for those who recognise the need for change in the ways and conditions of living in order to promote health. Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility to health to create a healthier future (WHO, 1984).

Recently, health promotion has adopted the idea of settings as a strategic way of implementing programs aimed at encouraging health-enhancing environments (WHO, 1991). The workplace, institutions such as prisons, and especially schools are seen to be contexts, or settings, calling for activities and policies that contribute to health promotion. Health promotion has similarly been influenced by recent studies on the social determinants of health. Social determinants define the importance of people's life and work contexts on their health. A recent publication by the Centre for Urban Health of WHO identifies the
importance of ensuring a good environment in early childhood as one of 10 interrelated aspects of the social determinants of health (Wilkinson & Marmot, 1998, p.7).

Despite the rich literature on health promotion and innovative uses of settings for health promotion, child care has rarely been considered in this context.

Review of the literature about child care centres and health promotion

Current literature from the early childhood education and health fields was reviewed. The review turned up only one article which explicitly linked child care to health promotion (Hewes, 1998), and one article which suggested that the link between health promotion and child care needs to be developed (Jenkins & Jeavins, 1999). The following categorisations developed from the literature review: literature about health promotion in schools; literature about health in child care settings written for and by early childhood professionals; and literature about health in child care settings written for and by health professionals. A summary of the literature is given below.

Literature about health promotion in schools

The literature on health promotion in schools comes mostly from reports and government documents. The focus of the literature is on:

- the development of self-esteem so that students value healthy lifestyles;
- the means by which schools can collaborate with students on the development and implementation of social aims;
- the importance of good relationships amongst all players associated with school environments;
- ways to stimulate staff and student collaboration; and
- the provision of stimulating challenges for staff and students (National Health and Medical Research Council, 1996; WHO, 1999; WHO 1999a; WHO, 1999b; Downie, Fyfe & Tannahill, 1990).

Suggestions are also given for using the school's structure and organisation and building to promote health. The literature especially emphasises the value of collaboration and linkages between schools, home, and communities (WHO, 1999; WHO, 1999a; Downie, et al., 1990; National Health and Medical Research Council, 1996; Bunton & Macdonald, 1992). No article was found which connected health promotion in school with the possibility of health promotion in preschool or other early childhood settings.

Literature about early childhood settings in early childhood sources

The literature identified the following as (macro) indicators of quality care:

- respect for language, culture, and religion of families;
- positive work environment for staff;
- communication between home/centre;
- collaboration with community organisations; and

A number of articles within this category fell under the heading of brain research. These include studies which show that the brain continues to develop well into the second year of life. These findings have reinforced the importance of early environments for children, including child care settings. Brain research has proven that early experiences are critical to later developmental outcomes in both neuro-physiological and social-psychological ways (Lally, 1998; Lally, 1998a; Nash, 1997).

Literature in this category—written for and by early childhood educators—also refers to the importance of addressing health and safety issues (hygiene) in child care centres. This hygiene emphasis, however, is generally situated within a wider context. A focus on minimising the spread of infection is shown to be one (but not the sole) aspect which contributes
to child and family wellbeing (Griffin, 1992; Taylor & Taylor, 1994; Kendrick, Kaufmann & Messenger, 1995; Watt, Roberts & Zeisel, 1993; Robertson, 1998).

**Literature by and for health professionals**

Literature which is disseminated to health professionals through journals and other sources was reviewed. Information from these sources is likely to be passed along to families and other members of the public by the health professional.

The articles in this category focused almost exclusively on the prevalence of infectious disease in child care centres. Warnings are given about the incidence of infectious diarrhoea, upper respiratory tract infections, otitis media, gastroenteritis, conjunctivitis, and skin infections. Statistics are cited to show how these infections may be up to twice as prevalent in children who are in group care (Ferson, 1994; Middleton, 1995). Many articles include descriptions of strategies which will minimise the spread of disease. There is an emphasis on the importance of washing hands, wearing rubber gloves, disinfecting toys, separating children by age and/or by toiletting skills, excluding and/or isolating children when sick. No mention is made of the psychological or emotional needs of children who are ill (Ferson, 1994; Krilov, Barone, Mandel, Cusak, Gaber & Rubin, 1996; Middleton, 1995; Nijenhuis, 1997).

Researchers found one exception to this negative picture of health in child care centres. The *Journal of Paediatric Nursing* reports on a project whereby a community health nurse spent time in a child care centre. This collaboration resulted in a significant reduction of upper respiratory infections at the centre. This article emphasises how interaction with parents and collaborative efforts between professionals facilitated improved hygiene practices and, more importantly, how the partnership between health and early childhood staff resulted in attitude changes in both professionals and client families (Ullione, 1997).

Overall, the tone of the literature in this category was cautionary about the use of childcare. The information given was not tempered by descriptions of the many practices which contribute to the wellbeing of children, families, and staff in child care centres.

While the important message of disease prevention must be disseminated, there is a concern that too concentrated a focus on disease could be overshadowing the equally important role of health promotion for child care centres.

**Are child care settings health promotion settings?**

A team of researchers from the University of Western Sydney studied the link between health promotion and child care centres (Hayden, Macdonald & Elliott, in press). The research study was developed to address the following question: "To what extent do child care settings incorporate health promotion in service delivery?" (see Macdonald & Hayden, 1999).

**How centres rate on hygiene practices and health promotion practices**

A rating checklist was developed from the booklet entitled *Staying Healthy in Child Care* (National Health and Medical Research Council, 1997). This booklet has been distributed to all child care centres in Australia. It contains strategies for minimising the spread of infectious disease in group settings. The checklist was implemented by 40 observers in 40 centres on the same day in May, 1999. Centre staff were not aware of the content of the checklist. Centres were rated according to the frequency by which staff implemented the recommended 'hygiene' practices (for example, washing hands after each nappy change). Of the 40 centres observed, 67 per cent were rated as following a majority of recommended hygiene practices most of the time or all of the time. [Hygiene practices were given a rating of 0–3 according to frequency of observation: never (0), sometimes (1), most of the time (2), all of the time (3). Scores were averaged across 12 items for each centre.]

Implementation of health promotion activities in child care centres was assessed through interview questions to teachers and directors. Responses to 20 open-ended questions were rated for frequency. The interview questions were adapted from the publication *Effective School Health Promotion: Towards Health Promoting Schools* (NHMRC, 1996, pp.5–9). A high percentage of services (over 85 per cent of the sample) reported that they engaged in
activities which are considered to be health promoting, although most respondents were unfamiliar with this term. Box 1 lists the health promoting activities practised by over 85 per cent of the sample.

The interviews revealed some gaps in health promotion activities (and related indicators of quality care). Centres were found to be lacking in two key areas. Scores were low for the incidence of practices which involved parent participation. Box 2 lists these practices.

The percentage of respondents who engaged in practices which involve collaboration with community services was also low. It was found that collaboration between health and early childhood professionals is not widely practised. Eighty per cent of child care staff reported that they liaised with health professionals on an 'as needed' basis only, not as a matter of course in planning health promotion and/or preventative tactics. The majority of centre staff stated that health professionals had not approached them for collaboration on any matter. (See Box 3).

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**Box 1**

**Health promotion activities which are being addressed in child care centres in NSW**

On open-ended questions 85 per cent or more participants reported that their child care centre engaged in health promotion activities such as:

- involvement of children in caring for the physical environment of the centre
- ensuring that children participate in decision-making, guide their own development, are challenged and stimulated, have access to creative, physical, social, and cognitively challenging activities
- ensuring that all children and families have equal chance to participate in all centre activities
- allowing for identification and support for special needs of children
- contributing to an environment where bullying and other forms of aggression are disallowed
- including role modelling by staff on eating habits and conflict resolution
- using routines (meals/nappy changes) and transition times as times for positive interaction
- involving families in decision-making
- communicating with families in several/diverse ways
- reflecting a commitment to antiracism and multicultural programming.

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**Box 2**

**Health promotion activities related to parent participation**

There is a need to address this area of quality care/health promotion.

Findings include:

- Parent participation from families with diverse ethnicity is lower than that of other parents (7.5 per cent reported this).
- Some staff do not provide opportunities for parental participation (10 per cent reported this).
- There are indications of a lack of communication with parents (20 per cent of participants made comments such as 'parents do not respect what we do').
- Parents are not involved in decision-making around nutrition and hygiene factors (82.5 per cent reported this).
- Parents were not involved in decision-making about the physical environment of the setting. (Parents may take part in beautification projects such as gardening, but they are not making decisions in this area). (70 per cent reported this.)
Box 3

Health promotion activities related to community collaboration

There is a need to address this area of quality care/health promotion. Findings include:

- Ethnic staffing which reflects the composition of the community was reported in only 17.5 per cent of settings.
- Less than 50 per cent of sample had a program to assist with transition of children to their next setting (school).
- Only 50 per cent of the sample stated that they regularly liaised with other professionals in the community such as police, government departments, and health professionals.
- More than 80 per cent of child care staff reported that they liaised with health officials on an ‘as needed’ basis only: they did not collaborate on preventative or other programs.
- No setting referred to liaison with community service agencies such as ethnic associations, churches, homes for the elderly.
- Centre staff did not report attending or contributing to community events. Most stated that logistics prevented this.

From Hayden, Macdonald & Elliot (in press)

Discussion

The literature reviewed contains descriptions of health promoting practices in school settings and descriptions of quality care in child care centres. While researchers did not find more than one article that specifically made connections between health promoting settings and child care centres, the identification of quality child care and the indicators of a health promoting setting appear to be uncannily similar. These include promoting intersectoral collaboration, networking for families, creating linkages, and other aspects of fourth discourse (family and community oriented) activities. Thus the literature indicates that the goals and practices in child care centres are similar to the goals and practices which are identified with the health promotion movement.

The literature from the health field about child care centres was shown to reflect a negative tone, emphasising caution in the use of group child care outside of the home.

An assessment of 40 child care settings in NSW revealed that child care centres were performing many of the strategies associated with health promotion. Two areas associated with health promotion/quality care were shown to need further attention. These were parent participation and community collaboration.

Conclusion: Coming full circle

Traditional interest in the ‘health’ dimensions of child care centres has tended to focus on them as sites potentially rife with disease. The outcome of this focus has been the development of guidelines, policies, and regulations whose major aim is to minimise the spread of infectious disease. There is concern that this focus on disease and its prevention (a hygiene approach to child care) could interfere with micro practices such as the need of the child for closeness, touch, and human interaction, and could subsume macro goals such as the facilitation of relationships and linkages for families and community services.

The research reported in this article raises the following questions: Can early childhood practitioners (and others) move beyond the messages of disease they are receiving from the health field? Can they focus on positive health promotion activities at the same time as they concentrate on disease prevention activities? Can they communicate a positive image of child care in light of the health literature which stresses the dangers of the spread of infection?

We believe that all this is possible and that high quality early childhood settings can, and must, lead the way as health-promoting settings. Ironically, more than two decades ago, Bronfenbrenner
identified the importance of settings (home, playground, day care centres) in influencing the ecology of human development (Bronfenbrenner, 1979, p.22). Thus in the new millennium early childhood education comes full circle. Bronfenbrenner’s notion of ‘settings’ as the locus for analyses, for policy development, and for practices which promote healthy development and wellbeing provides the framework for the suggested relationship between health promotion, quality child care, and the fourth discourse of early childhood education which focuses upon linkages and collaboration.

This ethos deserves to be recognised. A partnership between the domains of early childhood education and health is needed. This will involve increased awareness by health professionals of the role of health promotion practices in child care centres. Health professionals will need to be willing to share their ‘ownership’ of health matters and to acknowledge the essential contribution of other players in early childhood settings. The partnership also calls on early childhood workers to acknowledge their responsibility as health promotion agents and to facilitate a more active role for parents and community groups in the process of health promotion.

In the new millennium, partnerships and collaboration with health professionals and especially with the health promotion movement, will consolidate an increased leadership role for early childhood professionals in this arena. These linkages will serve two purposes. They will strengthen the conceptual base of the settings approach to health promotion, and they will lay the foundations for health promotion and for an expanded definition of quality care in early childhood centres.

References


World Health Organisation (1999b) WHO’s Global School Health Initiative Health Promoting Schools. Internet: WHO.


End notes

1. It should be noted that the centres were not randomised but chosen for convenience of location by the observers. The results therefore must be considered to be indications only.

2. The authors are engaging in further research to address these issues. Appreciation is extended to Sydney Water and Western Sydney Research Institute for their generous support of these projects.