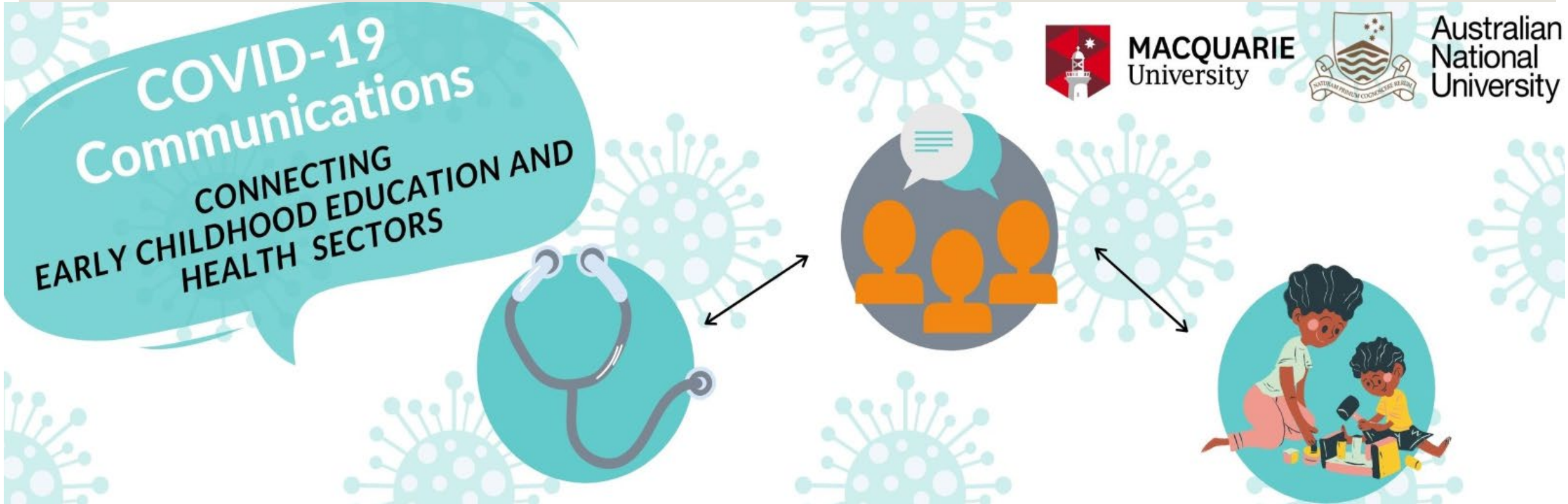
COVID-19 and Health Communication in Family Day Care Services

FAMILY DAY CARE ASSOCIATION NATIONAL CONFERENCE, HOBART, SEPT 2022
WORKSHOP

PRESENTED BY LINDA HARRISON, SHEILA DEGOTARDI, SANDIE WONG AND MANJULA WANIGANAYAKE



PROJECT TEAM

Sheila Degotardi
EC mixed methods researcher, extensive research leadership skills.

Sandie Wong
EC mixed-methods researcher. Expertise in service and ECE system evaluation.

Linda Harrison
EC quantitative and qualitative researcher. Extensive history of leading successful research – industry partnerships

Manjula Waniganayake
EC qualitative researcher. Expertise in leadership, policy, workforce development and diversity.

Fay Hadley
EC qualitative researcher, specialising in centre-parent partnerships, including those with diverse families.

Dũng Trần
Quantitative and qualitative approaches to studying functional uses of mathematics in home and work life

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Rebecca Bull
Quantitative (statistical modelling) and qualitative approaches to studying ECE systems.

Yvonne Zurynski
Health services & health systems and child health researcher. Expertise in policy analysis, systems and network analysis.

Mary Dahm
Qualitative & linguistic discourse researcher, specialising in the communication of complex health information..

Janaki Amin
Infectious diseases epidemiologist. Extensive track record in collaborative research with multi-disciplinary teams.

Michael Donovan
Expert in Indigenous education, with extensive history in working collaboratively with Indigenous communities.

Collaboration as a central design principle

Stakeholder meeting 1

Advise	On design and recruitment / access

Stakeholder meeting 2

Contextualise and interpret	Research findings

Stakeholder meeting 3 & 4

Co-create and ultimately distribute	Recommendation and Guidelines

The problem, the opportunity, the challenge

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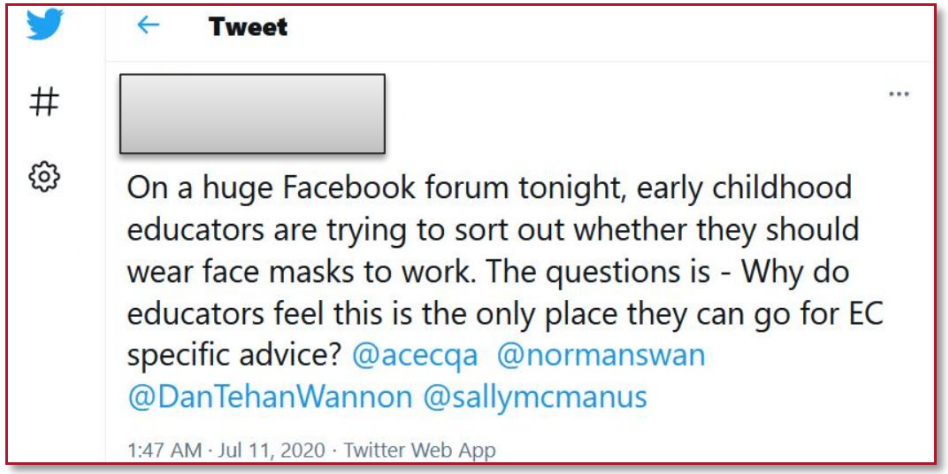


The potential

The ECE sector showed it has the capability and the reach to be effective health communicators in times of crisis.

Vision for the MRFF project

- to understand the experiences and learnings from these experiences of the ECE sector during the COVID-19 crisis,

and from this

- to develop a Best Practice Model of public health communication to be used whenever population-level health information needs to be communicated rapidly, accurately and effectively to families of young children and their educators in ECE services.

A Partnerships Model of Knowledge Brokering

A Partnerships Model of Knowledge Brokering

Research Questions

Document Analysis

OUR METHODS

- Documents extracted from publicly available sources (websites) and provided by partner organisations

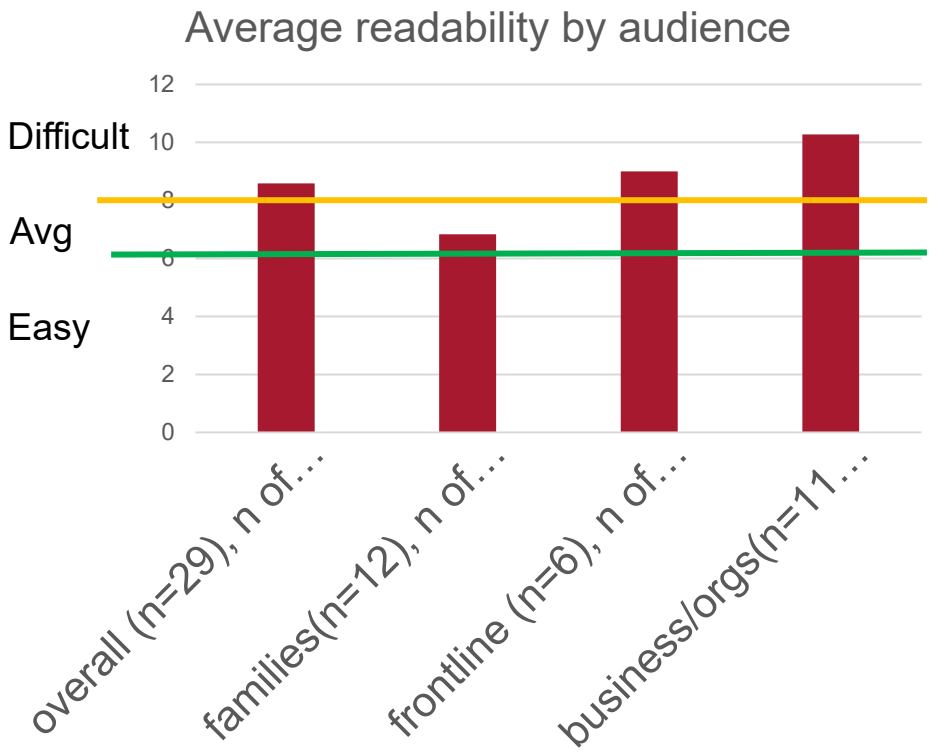
Total 825 documents:	Selection criteria	Selected for analysis
• External *n* = 594 • Provided *n* = 195 (9 organisations) • Redirected *n* = 36	• From Sector: ECEC, Health, CALD/Indigenous; • To Audience: Families, Frontline, Business;	• External *n* = 33 • Internal *n* = 16 (9 partner organisations)

- Our analysis focus was based on
  - Readability
  - Health information (content)
  - World Health Organisation (WHO) Communications Framework
    - Accessible
    - Actionable,
    - Credible and trusted
    - Relevant
    - Timely
    - Understandable

Document Analysis

MAIN FINDINGS

1. Information about hygiene, distancing and exclusion dominated.
   Information about the virus and how it spreads was limited
2. Most external documents for EC organisations and frontline staff were ‘difficult to read.’
3. The majority of documents included numerical information that required some inference or analysis, making this information relatively difficult to understand.
4. Much of the advice to services and educators was ‘indirect’ – i.e. words like ‘may’, ‘might’, and ‘could’ left the advice subject to interpretation. The directness of the same advice could vary within one document.



Elite Interviews

OUR METHODS

- Interviews (lasting up to 1 hour) were conducted via Teams, audio recorded & transcribed.
- 20 participants from 16 organisations:
    - Health *n* = 4
    - ECEC *n* = 12
    - National / Federal Organisations / bodies
    - 4 states and / or territories
- Transcriptions sent to participants for checking. Approved transcriptions used for analysis.

- Our analysis focus was to identify
    - What occurred in terms of the communication of health information from and to 'official sources' and 'educators':
    - What worked well, and what might need to happen differently to support the accurate and timely communication to and within the ECE sector and their communities in the future.

Elite Interviews

OUR MAJOR FINDINGS

1. **The complexity and diversity of the EC context impacts on the types of information sought by the EC sector, where it is sourced from and how it is communicated.**
   - Differences in the roles & responsibilities of organisations
   - Different goals, purposes, audiences & intentions
   - Other extrinsic factors impacted:
     - working from home rules
     - funding concerns
     - perceptions of EC sector in the community
   - Importance of advocacy

We need to be a little bit careful in what our role is in that space … of telling our members and directing our resources that have a very specific mandate that's governed by our constitution, and our mission, and our organisational vision etc – for us to be stepping into that space which kind of sits outside of our mandate, it presents some challenges.

We were also dealing with pretty dramatic funding and policy changes, often within weeks of each other – it was a very busy

It was an ethical or moral obligation on us to ensure that as many people saw and heard

Elite Interviews

OUR MAJOR FINDINGS

2. EC organisations *sought* information that was:

- Accessible (one trusted source of truth)
- Timely
- Clear
- Contextualised

We really had to piece together the advice from various sources. It didn't come in the one spot

Elite Interviews

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OUR MAJOR FINDINGS

3. Major challenges to accessing information:

- No clear lines of communication
- Information changed rapidly
- Health information wasn't always communicated clearly: Inconsistent & ineffective
- Information not specific to EC sector and/or to service types
- Information not contextualised to geographic locations
- Little evidence of health seeking information / input / feedback from EC – EC wanted two-way communication.

One of the things that happened for us was every – so at the beginning, information would go out to schools to say you need to do X, Y and Z. The media would get hold of it and go, "Oh my God, schools are now doing this," or, "Not doing that." And then the early childhood sector would then get all worried and anxious and start bombarding us with queries, "Schools can't do this. Can we do this?" Singing was a big one. "Schools can't sing, can we sing."

That was a huge problem for us, thinking well, "We operate in Victoria, do we go by the Department of Ed in Victoria and the health department or do we listen to New South Wales, because we're based in New South Wales?" And look, honestly, they're still not agreeing sometimes and I think was the hardest thing. I don't know how standalone centres manage that information, to be honest

Elite Interviews

OUR MAJOR FINDINGS

4. The EC sector used multiple approaches / processes to *communicate* health information to educators. Organisations:

- Assessed the quality' of the information (multiple approaches)
- 'Interpreted', 'translated' &/or 'transformed' information – to make it more accessible & relevant to their audience
  - Not a great deal of mention translation into community languages
- Developed new &/or adapted existing communication channels (e.g. email / videocasts) & used multiple modes of communication
- Organisations were agile
- Collaboration across EC organisations (sharing resources etc)

I think that the culture of this organisation is generally collaborative though. And that's one of our company values – so when this started to happen, and it started to escalate, it was initially just me tyring to kind of wade my way through it, and then a whole team came together and the business adapted really quickly to communicate all the information out in best it could. And I think it's those kind of individual

The other thing that we found, which kind of emerged, as we were doing the factsheets and the true facts of health, we needed to then develop resources for staff on how to put these things into practice in terms from the child's point of view on just why aren't all the staff there? You know, why are people wearing masks? Children were great, they knew all the health and safety and they didn't struggle with that.

Elite Interviews

OUR MAJOR FINDINGS

5. Multiple factors impacted on 'end-user' 'take-up' and/or understanding of health messages:

- Intrinsic factors – related to educators - Importance of relationships noted here
- Organisational factors (trusted source / resources etc)
- Socio-political factors (social media etc)

We'd just come out of another high risk crisis. We'd come through the bushfires. People trusted our team. And I was the voice that communicated those types of messages through both of those crises. So you've already got the benefit of they trust you, that you give good, clear advice, that they can use, it's practical. But you also become someone that they can turn to if they're unsure. And I think when you're in a situation like COVID where you have a large amount of information out in the public domain, confused messaging from government, lots of media, plus what's happening on social media, giving people a voice that they can turn to, and trust, and listen to, helps bring everyone's anxiety down.

Elite Interviews

OUR MAJOR FINDINGS

6. There was agreement that ECTs have the ability to be conduits of health information between ‘health’ and families ***but*** concern was expressed about this being an additional burden on educators.

Elite Interviews

OUR MAJOR FINDINGS

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7. Communicating health messages required significant organisational resources and this places a burden on the EC sector

I think I worked 270 days straight

So I remember thinking a lot of my friends were talking about how bored they were working from home. I don't think I've ever worked as hard as I did this last year where we were literally re-writing policies

…my day would run from, I'd get up about 4:30, I'd read any media that had generated out overnight, particularly from overseas. So I was very interested in the global media and what was coming through, particularly around early information on the medical front. But also how other organisations were responding, particularly in the education setting. And then having that – sort of before that media – you could download all that media. And then I would meet with one of my team at 7, my 2IC. We'd go through what we'd both established. We sort of split out who looked at what, so it wasn't such a big download. We review all the calls that came in from our team.

Surveys

OUR METHODS

An online SURVEY was developed and with questions adapted for four groups of ECEC participants:

- Family day care educators
- Family day care service staff (coordinator, approved provider, children's services officer, etc)
- Centre and school-based staff (approved provider, director, principal, educational leader, educator, etc)
- Families

Surveys from a total of 504 PARTICIPANTS were analysed using statistical techniques and qualitative analysis

- 338 Families
- 366 ECEC service providers, managers, leaders, educators, support staff
    - Management/Leadership ROLE (162 participants)
    - Teacher/Educator ROLE (202 participants)

SERVICE TYPE reported by 258 ECEC providers, leaders, teachers, educators

- Centre or school (144 participants)
- Family Day Care (114 participants)

Surveys

OUR FOCUS

What health information sources were ACCESSED?

HOW OFTEN were health information sources accessed?

How easy was it to UNDERSTAND the information?

CONFIDENCE in accuracy of the information

Ability to IMPLEMENT the health information into daily practice

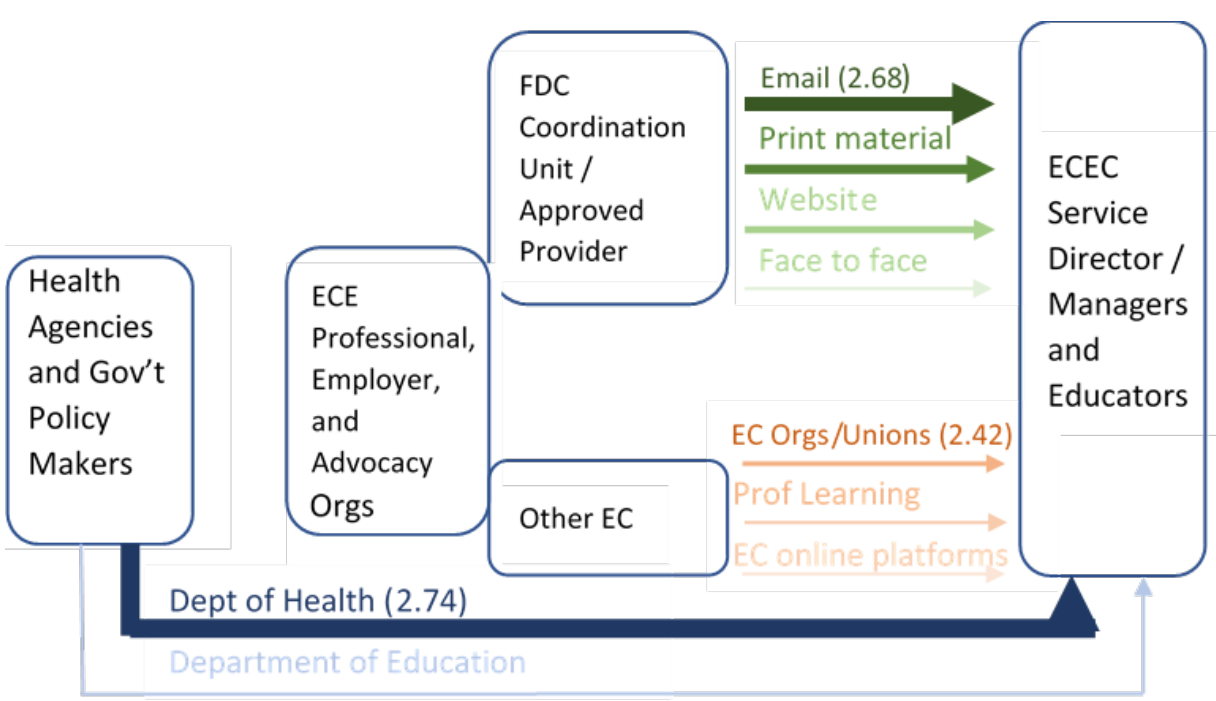
Effectiveness in COMMUNICATING health information with families

ACTIONS: changes made to BEHAVIOUR based on health information

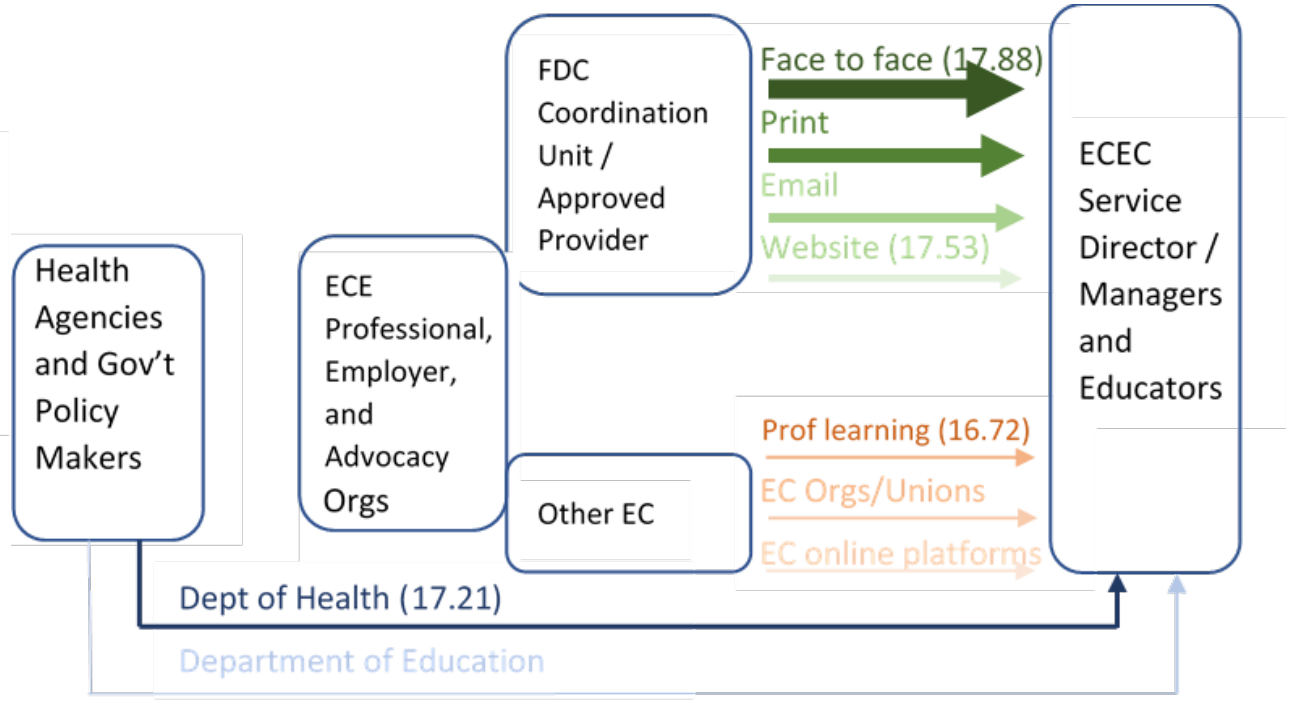
Information Access, Understanding & Confidence

MANAGERS (N = 162)

Information ACCESS from source (proportion accessing * frequency of using, max = 3)



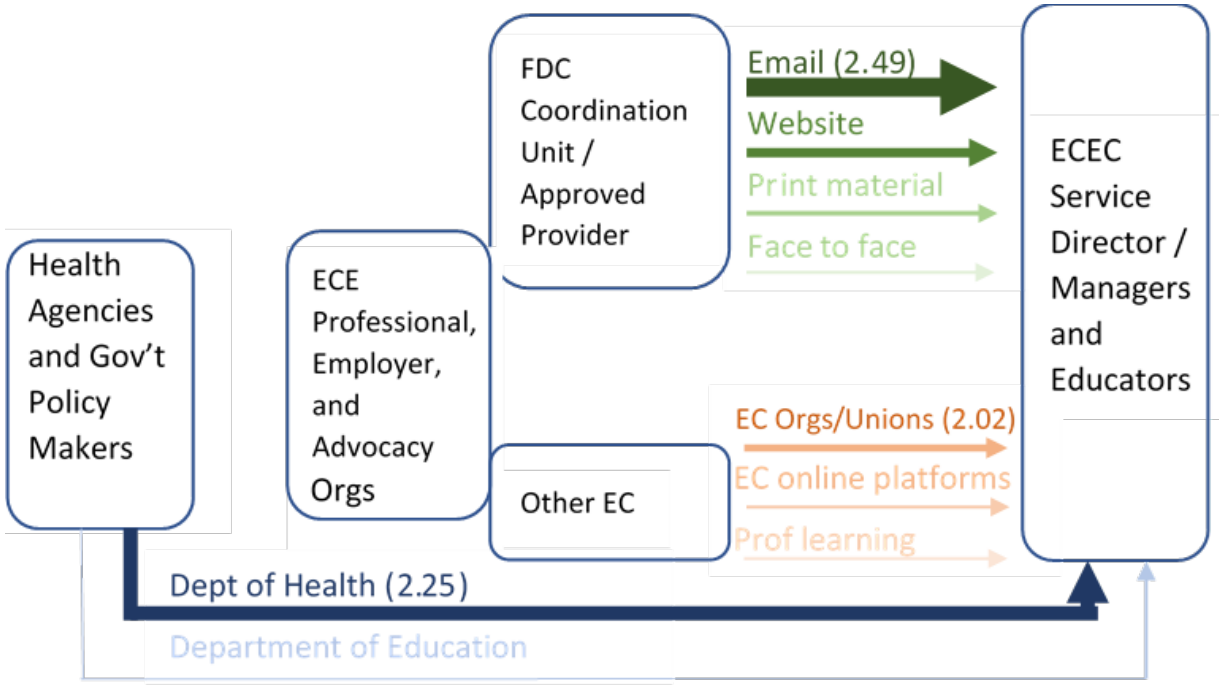
UNDERSTANDING and CONFIDENCE (max = 20)



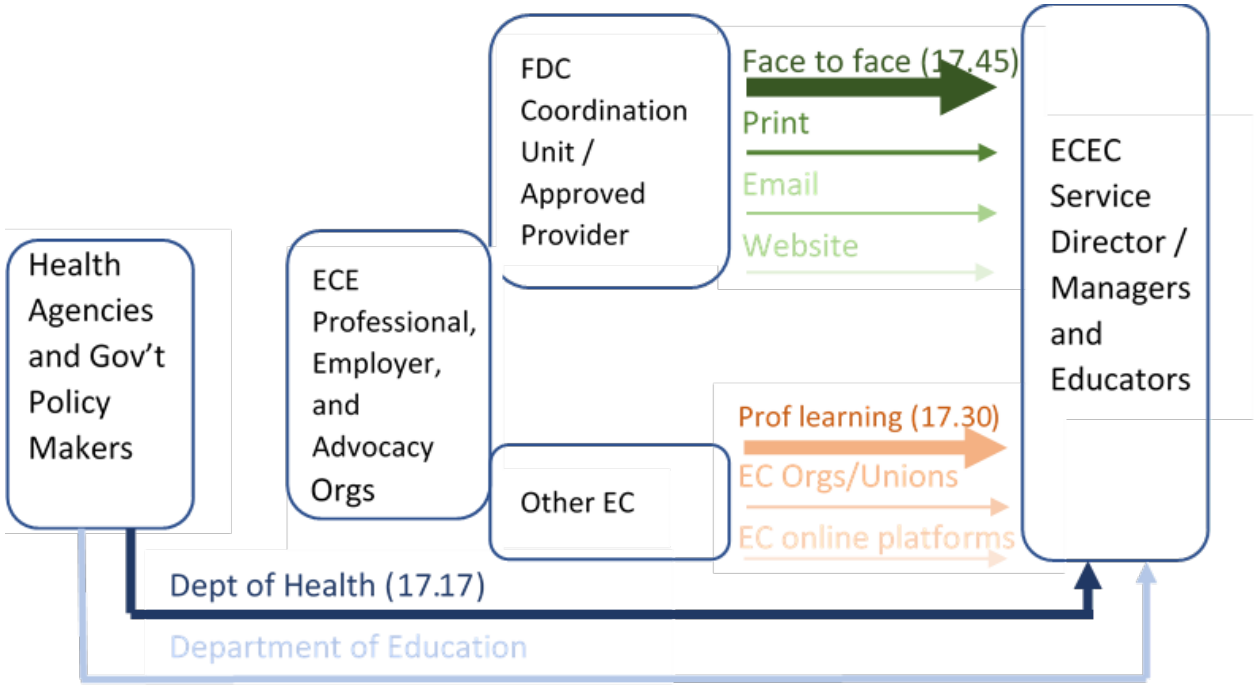
Information Access, Understanding & Confidence

EDUCATORS (N = 202)

Information ACCESS from source (proportion accessing * frequency of using, max = 3)



UNDERSTANDING and CONFIDENCE (max = 20)



Actions

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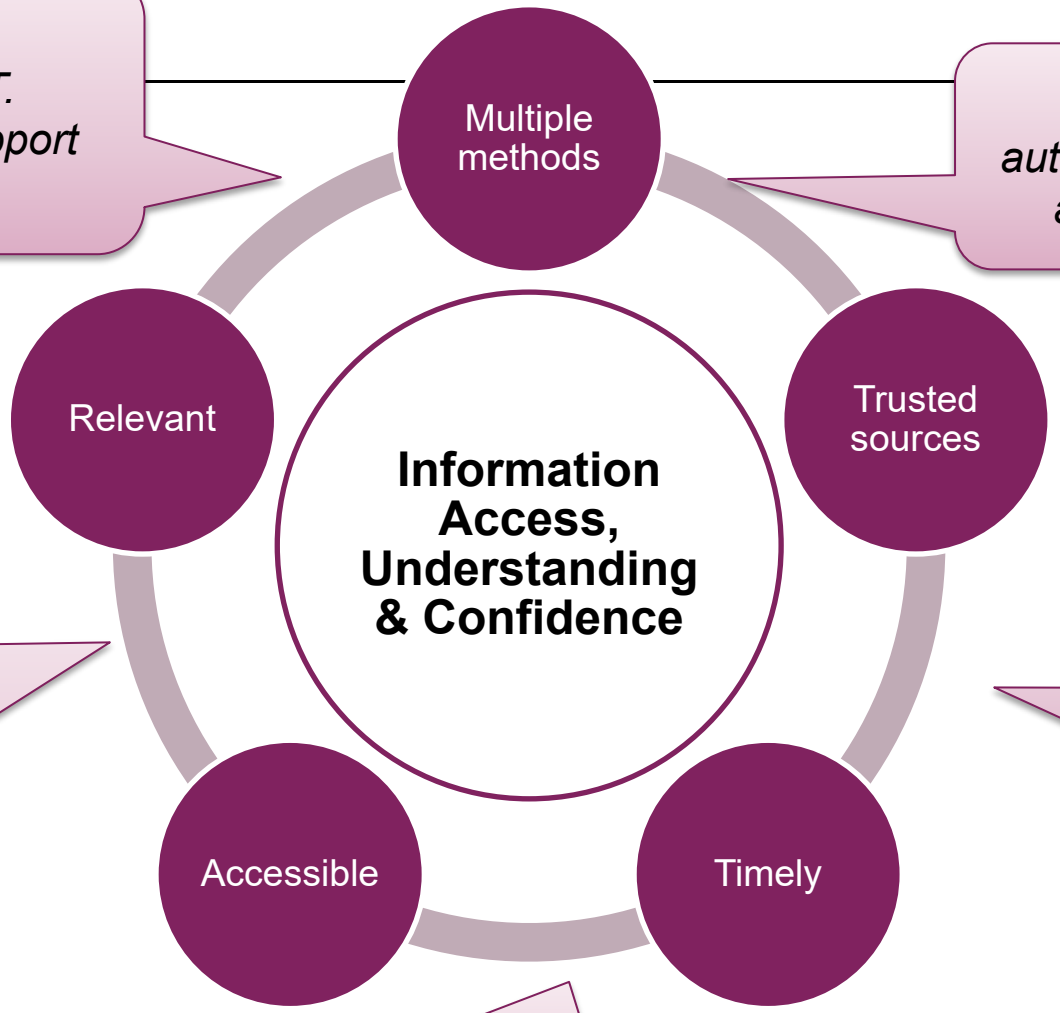
CHANGES MADE TO BEHAVIOUR BASED ON COVID-19 HEALTH INFORMATION RECEIVED FROM ECEC SERVICE

	Centre	FDC
Personal hygiene	65%	**83%**
Cleaning and disinfecting	54%	54%
Preventing spread of infection (e.g. excluding ill children/staff)	44%	**62%**
Preventing/limiting parents and visitors entering building	33%	40%
Operational (e.g. QR sign-ins)	33%	26%
Physical distancing	**36%**	20%
Monitoring for infection (e.g. temperature checks)	**31%**	15%
PPE (e.g. masks, gloves and shields)	27%	18%
Communicating to children	12%	**34%**
Communicating to families	21%	19%
Staff knowledge / awareness (e.g. self-checking websites, professional learning)	13%	15%
Other (e.g., wellbeing, reassurance, and anything else that could not be coded above)	13%	11%

What worked for managers and educators?

Regular briefings, Emails, Information bulletins from DET. Follow up from managers/ support to implement new protocols

Consulted health authorities and DoE, used a variety of methods



Being a Family Day Care service I found the messages were mainly concerned with Early Learning Centres, which left us with many grey areas.

Information was shared was consistent and people were referred to reliable sources.

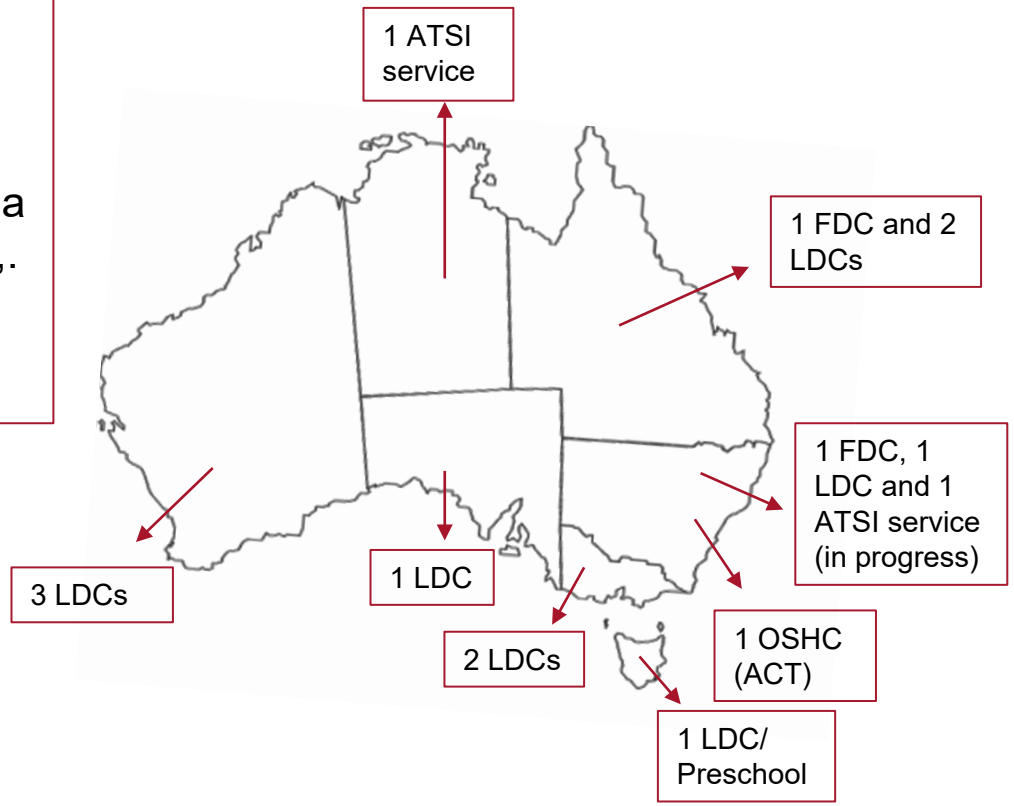
Regular updates provided especially as changes questions

Case Studies

OUR METHODS

- 13 education and care services:
  - ✓ Each state and territory
  - ✓ Metropolitan and regional locations
  - ✓ Mix of management types including FDC, OSHC, standalone and multi-site education and care services
  - ✓ Aboriginal and Torres Strait Islander communities
  - ✓ Culturally and Linguistically Diverse communities
- Interviews were conducted with owners/managers, educators, families by a research assistant, who was a member of, or familiar with, the community,.
- Transcriptions sent to participants for checking

Our analysis focus was to determine the localised health messaging experiences of each education and care service and their families.



Two of these services were FDC providers – one was community-based and one was privately owned.

FDC case study interviews (n=15) comprised of 2 managers, 6 educators and **7** parents/ caregivers**.**

Case studies

OUR MAJOR FINDINGS FROM FDC SERVICES - CHALLENGES

- **Overwhelmed by too much information** – *"There was a lot of information overload. And I remember going through phases where I was like emotionally blank, mentally blank. I couldn't process it" (FDC Educator)*

- **Heightened service/educator health compliance and monitoring**
  - rigorous compliance with hygiene practices and monitoring children for symptoms
  - Concern about impact on educator mental and physical wellbeing (eg, stay involved with hobbies and time with own family)

- **Amplified sense of responsibility for keeping everyone safe**
  - Educators' role of promoting children's health and well-being - "*…according to [the] NQS, national quality standard 2, my main important role is to – in this pandemic, to monitor and keep all children healthy and safe, and help children to keep good hygiene" (FDC educator)*

  - *"I think our educators did a really good job, and also just maintaining the kids' health and being really strict with who was allowed at care and at what times." (FDC educator)*

Case studies

OUR MAJOR FINDINGS FROM FDC SERVICES - TENSIONS

- Regular compliance practices (health/hygiene) vs Federal/State pandemic rules – rapidly changing and confusing

- Schools closed vz FDC open & safe: Fears of safety of own family and FDC children and families – no specific guidelines for FDC

- Income vs sustainability of services – home-based business; government lacked understanding of implications for FDC; educators and parents declared that 'free child care' policy was unjust and stressful:

  " It was stressful, and then suddenly the government made the decision to provide free childcare, which put all of us down to 40 percent of our income, or even less. Some people did not even have an income through that period. So again maybe you don't have the security on top of that add to the emotional and physical stress. (FDC educator)

- Wellbeing of FDC educators vs children and families: Educator isolation -

  "As we can't physically talk, sit and talk, but through Zoom, at least we feel like we share our ideas, other educators share their ideas. It feels like although we are not physically in touch, but still through Zoom, we are in touch with each other and we spend quality time " (FDC educator)

Quotes from educators

(CASE STUDIES)

"For me, as an educator, emails are good but we also get so many emails a day. So I think for me it's that face-to-face conversation. And I feel comfortable enough to go to [the Director] and go, "Give me some more information," or "I'm feeling a bit unsure about this. Can you clarify? Can you help me with that?" And I guess we send information out with families, but I am more of a talker. So I will touch base with the families either at the end of the day or at the beginning of the day more, or giving a family a phone call and asking, "Is this OK time, or can you give me a call back when it is a good time for you?"

(Educator, LDC, SA)

"I think I did get – eventually did get all the information that I needed, but the way it was communicated was just very sporadic, and it was just like pages and pages of information that we had to get through. So if it was handed in like a streamlined manner, in a quick to access manner, it would have helped me because I'm just not, you know, doing one thing, I'm just sort of all in all in my setting. ….

"There was a lot of information overload. And I remember going through phases where I was like emotionally blank, mentally blank. I couldn't process it."

(Educator, FDC, QLD)

Case studies

OUR MAJOR FINDINGS FROM FDC SERVICES

- **Parents' strong appreciation** of efforts by the service and educators including
  - Sharing health information promptly – service leadership and educators trustworthy
  - Continuing to provide excellent education and care for children; and educators' meaningful involvement with children's learning.
  - Encouraging parents to focus on own mental health and wellbeing
  - Proactively taking action to keep all children and families stay safe including teaching children about COVID

- **Best information** was when it was:
  - Tailored /Specific – nuanced for the ECEC contexts like FDC
  - Easy to access, read and understand – cater for different levels of understanding
  - Timely – direct portal access for educators and families

- **Multiple methods of communication**: f2f conversations, text messages, newsletters, fact sheets, email, social media, WhatsApp alerts/group chats, visual signage/key words and QR codes

Case studies

A SHOUT OUT TO A SPECIAL GROUP - **A COMMENDATION**

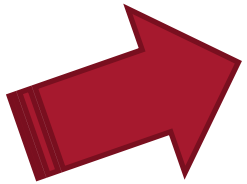
Family Day Care leading the way

"*There also was a very big support system during this time, was like the Truth About COVID-19 Facebook page. It was started by a few family day care educators…. And we could ask live questions, it was answered.*

Those ladies were going above and beyond in order to support the sector.

…..yeah, it was one place that we all felt safe and secure too."

(FDC educator)



Demonstrating leadership through initiative, drive and collaborative power