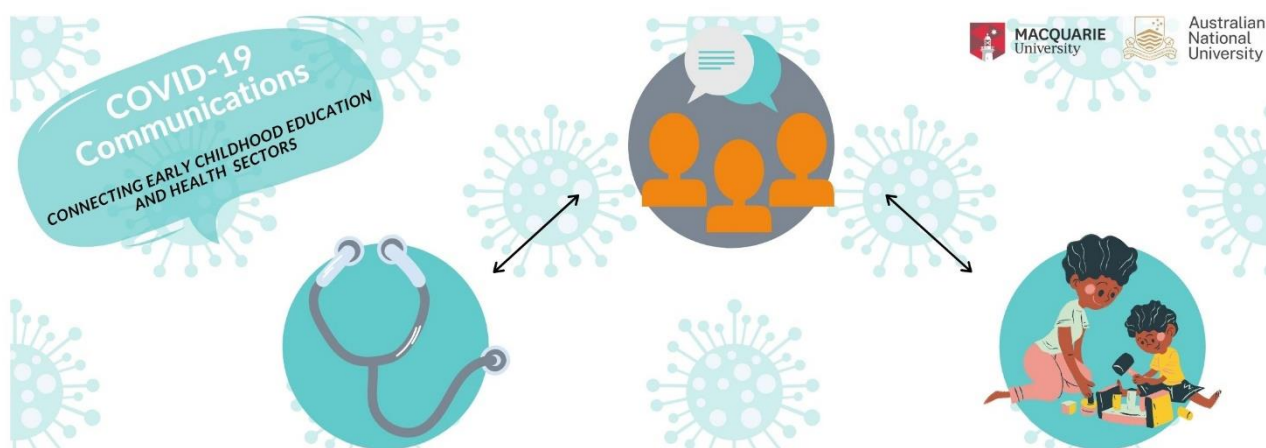


Harnessing the health communication potential of the early childhood sector



PROJECT REPORT AND RECOMMENDATIONS

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Executive Summary

STUDY CONTEXT AND AIMS

Throughout the COVID-19 pandemic the early childhood education (ECE) sector was continuously tasked with expanding their required health practices to include up-to-date evidence-informed interventions to prevent the spread of COVID-19 infections.

In this context, the Australian government via its Medical Research Future Fund (MRFF) invited research into the processes and challenges associated with population specific health communication. This report outlines the design of a multidisciplinary, multi-method, collaborative research project which sought to capitalise on learning derived from the experience of the ECE sector during the COVID-19 crisis. The ultimate aim was to develop a Best Practice Model of health communication for use whenever population-level health information needs to be communicated rapidly, accurately, and effectively to families of young children and their educators (Degotardi et al., 2020). The following questions guided the investigation:

RQ 1. What health information is received, sought, and communicated by the health and ECE sector to minimise the chance of infection of families and staff?

RQ 2. How does the ECE sector communicate health information to staff, families, and children?

RQ 3. What attitudinal, behavioural, and demographic characteristics are associated with process and effectiveness of the health knowledge translation and communication?

RQ 4. How can the Australian Government and the ECE sector work effectively together to harness the knowledge broker potential of the ECE sector for families with young children?

METHODS:

The mixed method design, generating quantitative and qualitative data, comprised three data sources:

- Health communication documents produced and disseminated by the health and Early Childhood sectors in response to the COVID-19 Pandemic.
- Survey data collected from educators working across a range of early childhood sectors as well as families using these services.
- Interview data with i) senior executive staff of peak organisations in the early childhood education health and community sectors and ii) service level directors/managers, educators, and family members in a targeted section of early childhood services.

The project was conducted by a multidisciplinary team with expertise in early childhood education, policy and leadership, medical science, public health, and health communication. A central feature of the project was the collaborative contribution of ten stakeholder organisations, including ECE employers, advocacy, workforce and health organisations representing the needs and concerns of the ECE service providers, educators, children, and their families who partnered with the academics. The researcher and stakeholder team worked collaboratively to co-design the methods, support the project implementation, interpret its findings and develop the recommendations and Best Practice Model.

SUMMARY OF FINDINGS

This project has demonstrated that the ECE sector has the potential to be a highly capable and effective health communication broker at times of pandemic health crises. Peak organisations, services and educators accessed COVID-19 health information and willingly supplemented their existing professional knowledge of infection control to adapt their regular health and hygiene practices in response to the COVID-19 threats. Our data identified the strong relationships that early childhood peak organisations and individual services have with their stakeholders, which meant they were regarded as among the most trustworthy and easily accessible sources of health information by the educators and families that they served.

HOWEVER, THIS STUDY IDENTIFIED SEVERAL BARRIERS THAT IMPEDED EFFECTIVE COMMUNICATION BY THE ECE SECTOR

1. Government and health agencies lacked awareness and appreciation of the context, practices, and concerns of the ECE sector.

Health messaging often did not address the ECE sector's immediate concerns. The language was often directed at school contexts, and recommended practice changes were difficult or impossible to implement in early childhood services. Whilst the ECE sector was described as an essential workforce, a lack of Government resourcing and acknowledgement of the infection risks in ECE services increased frustration and anxiety among educators, and created barriers to their willingness to place trust on government health information and advice. The ECE sector lacked a voice 'at the table' which meant it had minimal involvement with public health authorities when it came to formulating and communicating health messaging that was relevant and meaningful to service providers and the ECE workforce.

2. There was a lack of clarity around the health communication roles and responsibilities of health agencies, peak organisations, services and educators.

Respondents from ECE peak organisations spoke of the considerable time, effort, and resources they needed to allocate to generate health communication systems within their organisations - all of which was done at the organisations' own expense largely unrecognised by the Government. The sector emphasised the importance of having one clear and authoritative source of truth. The findings showed that implementation and communication would be strengthened if educators have a greater knowledge of the Government's strategy, and if they believe that the efforts of the ECE sector, collectively, has an impact on containing of COVID-19 infection.

3. There were too many lines of communication.

Health information was communicated to, and accessed by, the ECE sector via a wide array of different communication platforms and methods, but these multiple lines of communication presented a barrier to finding up-to-date and accurate information. The complexity of managing the implications of new health advice and orders caused delays in communicating new information to services, educators, and families.

4. There was a lack of clarity and consistency of health communication.

Many of the documents directed at ECE organisations and services were found to have a reading level higher than recommended for general audiences and to contain health advice written in complex and hedged language making it difficult to interpret and implement. Managers and educators reported that health communications were often lengthy, which posed difficulties in extracting the main messages for their practice. Documents directed at families and children were largely appropriate, but service respondents spoke of challenges related to passing on written material to families who may have responded more favourably to less text-based or face-to-face communications.

5. Health information lacked relevance to and accessibility for the target audience.

The health information and advice received by the ECE sector was perceived as lacking awareness of, and therefore relevance to, the concerns and practices of ECE services and their educators. Information was often communicated in a way that was perceived as being inaccessible by the target audience. Service managers/directors and educators were overwhelmed by emailed information, and reported that a lack of timely, easily accessible information left them unsure about current health orders and recommendations. They also reported limited evidence of health communication documents for culturally and linguistically diverse families and ECE educators.

6. Effective COVID-19 professional support resources were needed.

Educators acknowledged that professional learning modules were becoming available at the time the study was conducted, but lamented that these were often generic and difficult to apply to their own context. Managers and educators identified the importance of face-to-face or interactive platforms (such as Facebook) as support mechanisms. The difficult readability level of many COVID-19 documents indicated a need for professional development and support so that health and ECE organisations could produce clear, consistent and actionable health messages for educators and families.

RECOMMENDATIONS:

STREAMLINE AND COLLABORATE

Recommendation 1: Establish a national pandemic and health-crisis response strategy for the ECE sector to support consistency in pandemic management policy and procedures, as well as health messaging and advice throughout the country.

Recommendation 2: Increase representation of, and collaboration between, the Health and ECE sectors at regional, State and Federal levels by including ECE representatives on advisory boards and committees.

RESOURCE

Recommendation 3: Develop easy to access, read and understand health related resources needed by ECE service providers, staff, families, and young children, to support actionable responses to health emergencies.

CONTEXTUALISE AND SUPPORT IMPLEMENTATION

Recommendation 4: Allocate funding for local health brokers, who will guide the implementation of health advice.

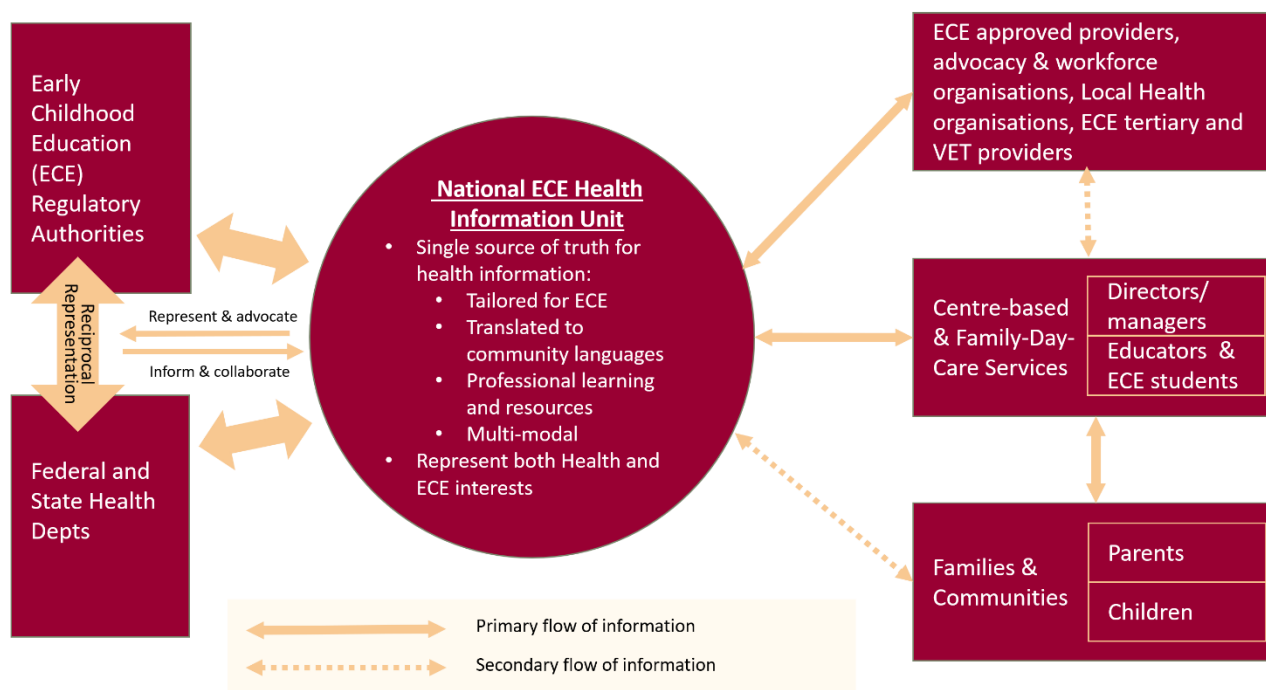
Recommendation 5: Establish systems for ECE localised face-to-face and/or online platforms for families and educators to provide interactive opportunities that are responsive to current and emerging local challenges and questions.

BUILD CAPACITY

Recommendation 6: Deliver professional learning modules to improve the individual’s capacity to understand, implement and communicate health advice.

Recommendation 7: Provide professional learning to upskill content producers who create health communication documents and resources to improve the readability, interpretability and overall effectiveness of health communication that is accessed and created by the ECE sector.

BEST PRACTICE MODEL OF HEALTH COMMUNICATION FOR THE ECE SECTOR.



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Based on our research findings and the seven recommendations, we propose a Best Practice Model of Health Communication. This model involves the establishment of a National Early Childhood Health Information Unit (ECHIU), which will facilitate the two-way communication of information between those issuing health orders and advice and the ECE sector, at organisational, service, and individual levels. The ECHIU would sit independently, without any specific employer group or management affiliation, yet would be respected and trusted within the ECE sector as the primary 'source of truth' for public health information. This unit would include experts in the system and practices of early childhood education and in public health and health communication. Its role would be twofold:

- i. To receive and translate up-to-date health advice and information from Government health agencies so that it is accessible, clear and relevant for the ECE sector.
- ii. To represent and advocate for the needs and concerns of the ECE sector to Government health agencies.

A full discussion of how this model will address the research recommendations can be found on pages 19-20

SCALING UP THE MODEL/IMPLEMENTATION:

While the best practice model was developed in response to the ECE sector's experiences of COVID-19 health communication, this project proposes that this model could be scaled up to be a responsive and effective communication model in the event of any crisis impacting the health and safety of young children and their families (such as other infectious disease outbreaks, bushfires, floods, and droughts) in ECE services, and the community that the sector serves. The resounding finding of this research project is that the ECE sector exercises a strong and resilient ethic of care towards their family and staff communities, and take seriously their role in maintaining the health, safety, and wellbeing of their communities. With the appropriate support recommended in this report, it is clearly possible to harness the potential of the ECE sector to be an effective and trusted communicator in the face of future health or safety crises.



Full Report

INTRODUCTION

A guiding principle of Early Childhood Education (ECE) professional practice is the adoption of pro-active measures to protect the safety, health, and wellbeing of children, their families, and educators. In Australia all approved early childhood services must adhere to the guidelines established by the National Quality Standard in children's health and safety, requiring services and educators to implement health and hygiene practices that will minimise disease transmission amongst children, staff, and families.

The ECE sector was deemed an essential workforce by the Australian Federal Government throughout the COVID-19 pandemic. During this period, the ECE sector was arduously tasked with expanding their health practices to include up to date evidence-informed interventions to prevent the spread of COVID-19. This considered, there remains a lack of research regarding how educators and services undertook and experienced the process of accessing and communicating COVID-19 information. Current information highlights the systemic challenges related to the sourcing, communicating, and implementing of critical health communication, with educators stating that they felt unsupported and underprepared to effectively deal with COVID-19 related demands and strategies (Park et al., 2020; Pramling Samuelsson et al., 2020).

The Australian government, through its Medical Research Future Fund (MRFF), announced an initiative to fund research into the processes and challenges associated with population-specific health communication. The research project presented here aligned with this initiative, adopting a partnerships model of knowledge brokering. This allowed the researchers to engage closely with a diverse range of ECE stakeholders, including ECE services, peak organisations, and families to build a comprehensive picture of COVID-19 health communication experiences, barriers, and enablers. The methods utilised, findings and subsequent recommendations of the research project will be detailed in this project report.

PROJECT AIMS AND VISION

This project sought to build on learnings derived from the experiences of those attending and working within the ECE sector throughout the COVID-19 crisis, to generate a Best Practice Model of Health Communication and recommendations that could be used in times of crisis whenever population level health information needs to be communicated rapidly and efficiently to all ECE stakeholders.

Brief glossary of terms

Early Childhood Education (ECE) Service – a service that is accredited to deliver early childhood education and care to children from birth to school age. ECE Services include long day care -services, preschools/kindergartens, and family day care.

Educator – a person employed by an ECE organisation to work directly with young children. This term is inclusive of all educators with a range of qualifications including Certificate III, Diploma and Bachelor's degree (ECT).

Manager – a person employed by an ECE organisation in a position of leadership, such as a service director or manager.

Staff – a collective term to capture all people employed by a particular service or organisation.

Family/ies – a collective term to capture parents, other familial caregivers, and non-familial guardians, as well as children.

Approved providers – entities who are approved to operate and ECE service or group of services.

Peak organisations – employer, membership or advocacy organisations who provide a strong representative voice for their stakeholder communities.

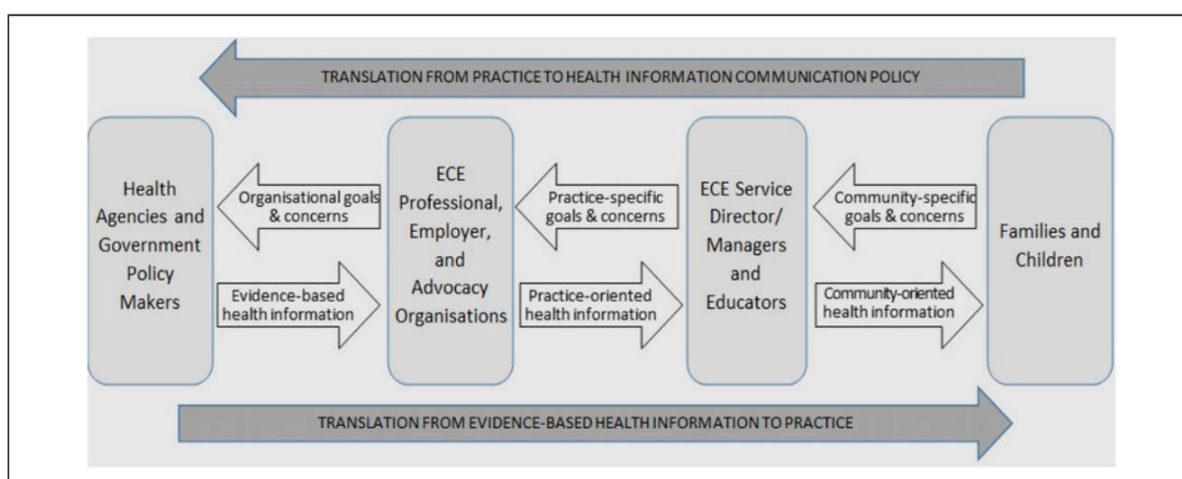
THEORETICAL BACKGROUND

This research project adopted a partnerships model of knowledge brokering, supporting the use of community-based knowledge brokers who collaborate with and act as an intermediary between health agencies and community end-users to communicate relevant information to both parties (Bornbaum et al., 2015; Dagenais et al., 2015; World Health Organisation, 2017). ECE services have been cited as pivotal in communicating health care needs during a health emergency, due to their in-depth knowledge of their stakeholder communities. The National COVID-19 health and research advisory Council 2020 stressed the potential of partnerships between health agencies and community groups to reach diverse communities. This research project acknowledged the ECE sector as an invested stakeholder with the knowledge and community-wide capacity to be an effective health communication knowledge broker to families and communities (ACECQA, 2020; Steering Committee for the Review of Government Service Provision, 2020). However, there are complications to consider in how health communication traverses the ECE sector. While some health brokering agencies assume a direct mediating role between a health authority and the stakeholder population, the ECE sector comprises multiple organisational levels, with each receiving and relaying information to their specific stakeholder community.

In this research project, we adopted a multi-level, partnership health communication approach (see Figure 1). At the 'peak' level, the sector comprises national professional organisations, employer organisations, and workforce or policy advocacy agencies. These organisations support the next sector level – ECE services and their staff – by providing the information required to support educators, families, and children. ECE service managers and educators had a direct role to play in communicating directly with their families and children.

Therefore, an effective ECE health information brokering system necessitates consideration of how evidence-based health information is efficiently communicated and translated at multiple points across the different organisational levels. An effective health information knowledge brokering system incorporates bi-directional, mutually respectful communication that considers the evidence-based information alongside practice and community-oriented goals and concerns of the target populations (Dagenais et al., 2015; Leask & Hooker, 2020), as shown in Figure 1 below.

Figure. 1 A Partnership Model of Health Communication to and through the ECE sector (Degotardi et al., 2022)



METHODOLOGY

RESEARCH PROJECT DESIGN:

The mixed method design comprised three data sources generating quantitative and qualitative data:

1. Health communication documents produced and disseminated by the health and ECE sectors in response to the COVID-19 pandemic.
2. Survey data collected from educators working across a range of early childhood (EC) services and families using these services.
3. Interview data with senior/executive staff of peak organisations in the ECE health and community sectors regarding the development and dissemination of health information, and
4. Interview data with service-level directors/managers, educators, and family members in a targeted selection of ECE services.

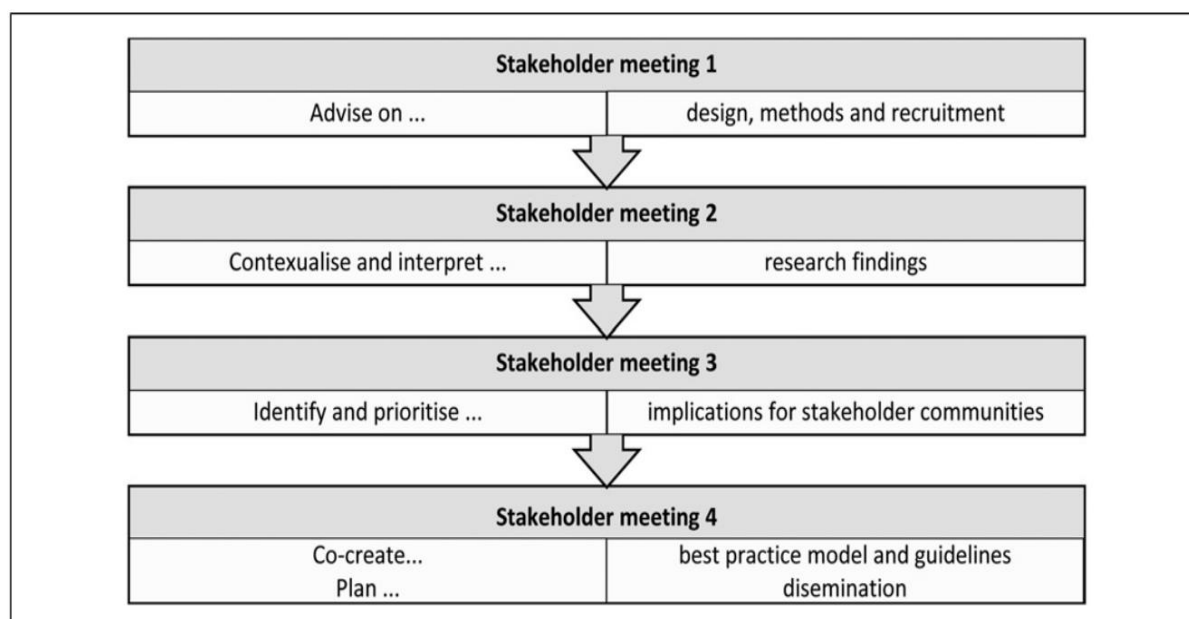
STAKEHOLDER COLLABORATION:

Stakeholder collaboration was central to this project. Stakeholder collaboration can facilitate participant recruitment, and, once data is collected, involvement also supports the meaningful and context-specific interpretation of the findings. In sum, collaborative research designs gain power from the “knowledge and methodology expertise of researchers with the local expertise and lived experiences of community members to collaborate for change” (Jacquez & Svindin, 2020, p. 6).

Stakeholder organisations from the ECE, health and community sectors partnered with the researchers in the design of this research project. Such collaborations capture meaningful stakeholder participation across a range of research activities including research design, data generation, interpretation, and dissemination, and have been argued to enhance the “rigor, relevance and reach” of translational research (Balazs & Morello-Frosch, 2013, p. 10).

In this project, ECE advocacy, providers and health organisations representing the needs and concerns of ECE services, educators, children, and their families, were invited to participate in a stakeholder collaboration. With the aim of incorporating active collaboration across the entire research process, we incorporated four stakeholder meetings into our research design. These two-hour meetings, held via Zoom, enabled the research team and stakeholder representatives to collaborate at each key phase of the project. The purpose and content of each meeting is represented in Figure 2.

Figure 2. The design, purpose, and content of the stakeholder organisation collaboration meetings



DATA COLLECTION/GENERATION:

Four data generation component methods were employed, capturing the varied health communication processes and experiences across the multilevel health communication model. The data generation and analysis details of each component are detailed in Table 3 below.

Table 3. Summary of data generation and analysis

Source	Data collection	Data analysis
1. <i>Component A:</i> A document analysis of relevant health communication sources.	<ul style="list-style-type: none"> Health documents were collected from publicly available websites and organisation-internal sources (provided by nine of our partner organisations). Documents included health policies and guidelines, health advice (e.g., FAQs, videos, factsheets, children's books, newsletters, and posters) and internal communication (newsletters, emails and briefings) directed at diverse audiences including health professionals, EC organisations, service providers, families and children. 	<ul style="list-style-type: none"> 825 documents- 630 externals (publicly available), 195 internal (supplied by partners). Data extracted consisted of title, document type, source, organisation, jurisdiction, producing sector, audience, language, release, and access dates. In depth analysis of 49 documents, 33 (external), 16 (internal). Document analysis was conducted by 4 experienced members of the research team using NVIVO qualitative data analysis software. Stepwise, iterative, and deductive approach adopting a combination of techniques including readability analysis, content analysis, numerical complexity analysis and linguistic discourse analysis.
2. <i>Component B:</i> Surveys completed by educators working in ECE services and families attending the services	<ul style="list-style-type: none"> Informed by current literature on responses to COVID-19 (Asia-Pacific Regional Network for Early Childhood, 2020; Dryhurst et al., 2020; Harris & Dakin, 2020), and the research teams' and partners' expert knowledge of the needs and concerns of the ECE sector Information was gathered about the educators' confidence in, and the effectiveness of, the health information that was provided by and accessed by educators and families. Sources included online, print and face-to-face communications from their ECE service provider and other ECE sources, such as professional development programmes, as well as government websites, television and radio, social media and from family and friends 	<ul style="list-style-type: none"> 257 families and 401 ECE educators and managers of centre-based and family day care services provided survey responses Qualitative coding using an inductive analytical approach (patterns and themes) to identify enablers and constrains of effective health communication and the implementation of health advice. Quantitative descriptive analysis examined the number of respondents who accessed each of the different sources of information, their ratings of confidence in the information and the effectiveness of the health messaging. Regression analysis examined whether confidence and perceived effective of the communication were influenced by educators' knowledge, attitudinal characteristics, and professional roles. . Path analysis examined direct and indirect effects of attitudinal characteristics and confidence in health information sources on educators' perceived implementation effectiveness.

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<p>3. <i>Component C1:</i> Elite interviews with EC and health organisations</p>	<ul style="list-style-type: none"> • Interviews were conducted in July 2021 with 16 representatives from key health or community agencies (n = 4) and EC (n = 12) organisations with combined reach across Australia (e.g., EC peak bodies; EC employer organisations, and advocacy organisations with a remit for providing professional support for EC services). • The 16 one-hour interviews were conducted via video link and audio recorded - 211 pages of 'approved' transcripts. • The semi-structured interviews were guided by overarching questions related to the type of health information they had access to relating to COVID-19; their roles, responsibilities, strategies and approaches in sharing this health information within their organisation; factors that influenced this communication; and suggestions for improving future communication of health information. 	<ul style="list-style-type: none"> • Inductive analytical approach consisting of coding and thematizing. • NVivo used and four interviews double-coded with NVivo reporting Kappa coefficients of 0.67– 0.87 which is fair–excellent • A final total of 2016 codes identified. • Codes were organised into themes using a hybrid inductive-deductive approach.
<p>4. <i>Component C2:</i> Case study interviews in targeted EC services.</p>	<ul style="list-style-type: none"> • Conducted in response to the findings from the C1 component. • 14 case study sites selected to include representation from each state and territory, from metropolitan and regional locations and from a mix of management types including for-profit and not-for-profit, as well as standalone and home-based services • Face-to-face and virtual interviews were conducted with service Directors, educational/ room leaders and educators (n = 50) and families (n = 18) • Topics centred on localised relevance and use of the COVID-19 health information, including any barriers in accessing this information; The extent to which the COVID-19 health information aligned with the National Quality Standards, including Quality Area 2 - Health and Safety; How critical information was shared and discussed with staff and families, including how information may have been tailored to address diverse communities; The resources educators received or accessed to support the children and families in their EC service 	<ul style="list-style-type: none"> • Qualitative analysis built on coding analysis of C1 elite interviews. • Interviews were audio recorded and transcriptions returned to enable participants to check amend and/or make additional comments. • Descriptive analysis of the case study after the interviews by completing a summary sheet regarding the common themes which the researchers referred to as contextual data.

FINDINGS AND RECOMMENDATIONS

This project capitalised on learning derived from the experience of the early childhood education (ECE) sector during the COVID-19 crisis in 2021. The aim was to develop a Best Practice Model of 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.

The project was conducted by a multidisciplinary team with expertise in early childhood education, policy and leadership, medical science, public health, and health communication. It was supported by ten stakeholder organisations, who worked collaboratively with the research team to co-design the study methods, to support its implementation, to interpret its findings and develop the recommendations and Best Practice Model.

In this document, we present a synthesis of the main findings derived from the i) health communication document analysis, ii) elite interviews with ECE and Health stakeholder organisations, iii) a national survey of ECE service managers/directors, educators and families, and iv) targeted case studies of diverse ECE services located across Australia.

We begin with an overview of the strengths of the COVID-19 health information brokering capabilities and efforts of the ECE sector, and progress to identify areas which constrained or challenged their efforts. Drawing on these findings, we then present a Best Practice Model that we believe can be applied to strengthen the flow of health information from government health agencies, to and through the ECE sector to services, educators, and families. We conclude with seven recommendations and a recommended Best Practice Model of Health Communication that, if enacted, would substantially strengthen the ECE health communication system, and provide government health agencies with a conduit through which to effectively communicate vital health information to a substantial and diverse portion of the Australian community.

THE POTENTIAL OF THE EARLY CHILDHOOD EDUCATION SECTOR AS EFFECTIVE HEALTH COMMUNICATORS

This project has identified that the ECE sector has the potential to be a highly capable and effective health communication broker at times of pandemic and other health crises. Peak organisations, services and educators accessed COVID-19 health information and willingly supplemented their existing professional knowledge of infection control, to adapt their regular health and hygiene practices in response to the COVID-19 threats. Our data emphasised that the strong relationships that early childhood peak organisations and individual services have with their stakeholders meant that they were regarded among the most trustworthy and easily accessible sources of health information by the educators and families that they served. Families highly rated the effectiveness of information they received from their ECE services. It was clear that ECE organisations and services went to great efforts to communicate health information in a clear and timely manner and endeavoured to do so in a way that was tailored to their stakeholder communities including families and children.

Organisations, services and staff brought their professional commitment to the health and wellbeing of their respective stakeholders to their COVID-19 pandemic response. Many peak ECE organisations took measures to ensure that the health information and advice that they were passing on to ECE services was correct and up to date. Service managers and educators took considerable steps to integrate COVID-19 health advice into their daily practice, taking seriously their professional responsibility to maintain a duty of care to staff and families. Our data also demonstrated the ability of the ECE sector, in particular at the peak organisation and the service management level, to respond swiftly, and be willing to pivot to re-allocate time and resources to provide a strong response to the developing health crisis. Many organisations swiftly developed new websites, resources and communication channels to maximise the effectiveness of their COVID-19 health communication. While this response involved considerable time and material cost, many ECE organisations and services shouldered the burden due to their strong commitment to the health of their communities. While some services and educators found that COVID-19-specific health information was difficult to source and understand, established professional networks and communication platforms and processes that exist both within peak employer organisations, and between individual services and peak ECE professional, representative and advocacy groups created effective communication channels that were trusted and regarded by most sector stakeholders as effective.

Despite the positive steps taken by the ECE sector to support young children, families and educators during

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the COVID-19 pandemic, this project identified several areas where the ECE health communication system could be strengthened. The findings relating to six major areas are summarised below:

1. GOVERNMENT AND HEALTH AGENCY AWARENESS AND APPRECIATION OF THE SPECIFIC CONTEXT, PRACTICES AND CONCERNS OF THE EARLY CHILDHOOD EDUCATION SECTOR.

This research found that the effectiveness of the COVID-19 health information and advice that stemmed from Government health agencies was impeded by a perceived lack of awareness and appreciation of the context, practices and concerns of the ECE sector. Health advice often recommended practice changes that were difficult or impossible to implement in early childhood services. The language used in many of the health communication sources were directed at school contexts and overlooked the very different education and care practices that occur in the ECE sector.

Our research participants also expressed frustration at health messaging and advice that did not address their immediate concerns. For example, the advice about low infection rates in young children ignored educators' strong and valid concerns about their own health and that of their families. While the ECE sector was often described as an essential workforce, the Government did not resource and largely did not acknowledge the infection mitigation efforts at ECE peak, service and educator levels. This oversight created frustration and anxiety among educators and services, which in turn created a barrier towards their receptiveness to placing trust on government health information and advice.

Interviews with representatives from the health sector identified that the complexity of the Australian ECE sector posed a considerable challenge to the effective communication of public health information. Health representatives consulted during the study's elite interviews, identified a lack of two-way communication as an impediment to effective health messaging. There was a realisation that they were dependent on the translation capacity of organisations such as Departments of Education to pass the information on to their stakeholders. Our findings suggest, however, that frequently the messaging targeted schools only, with little or no regard for the distinctiveness of ECE services.

2. HEALTH COMMUNICATION ROLES AND RESPONSIBILITIES AT ALL LEVELS OF THE HEALTH COMMUNICATION MODEL

Our research highlighted a lack of clarity around the health communication roles and responsibilities of health agencies, ECE organisations, services and educators. ECE peak organisations spoke of the considerable time, effort and resources that they allocated to generate health communication systems within their organisations. These efforts were done at the organisations' own expense and often relied on the conscientious good will of staff working within these organisations, which was largely unrecognised and unsupported at the Government level. Service-level managers also reported going to extraordinary measures, often outside of their normal work hours, to ensure that they accessed and understood the practical implications of the most recent health advice.

The sector at all levels espoused the importance of having one clear and authoritative source of truth. Many organisations were intentionally judicious in their choice of information source, and these organisations mentioned the Government Departments of Health and/or Education websites and communications as their 'source of truth.' Service managers and educators also reported that they frequently accessed Government and Department of Education websites and rated these sources as trustworthy and relatively easy to understand. Survey responses indicated that educators frequently accessed and rated highly the effectiveness of information provided by their early childhood employers and other peak ECE organisations. Collectively, respondents explained that ready access to trustworthy information not only provided confidence in the correctness of the health information and advice that they relayed to staff and families, but also limited the need for time-consuming information searches.

Our survey analysis identified that two key attitudinal variables –i) educators' trust in the information source, and ii) the perceived effectiveness of the messaging provided by that source - predicted the educators' perceived ability to implement the health communication advice and to communicate this advice effectively to families. These two attitudinal variables were themselves predicted by a) educators' knowledge of the Government COVID-19 strategy and b) their sense of collective efficacy defined as their belief that the efforts of the ECE sector can impact the spread of COVID-19 in the community. In other words, our findings

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suggested that health advice implementation and communication will be strengthened if educators have a greater knowledge of the Government's strategy, and if they believed that the efforts of the ECE sector, collectively, has an impact on containing of COVID-19 infection.

3. LINES OF COMMUNICATION

The document and survey analysis indicated that health information was communicated to, and accessed by, the ECE sector via a wide array of different communication platforms and methods. Most educators and managers reported accessing information from more than four different sources, with information from National and State Departments of Health and/or Education and approved ECE Providers accessed most frequently. However, the multiple lines of communication presented a barrier to the effectiveness of the communication. Participants reported that the sheer number of sources was a barrier to finding up-to-date and accurate information. Some educators reported confusion about which sources they should consult for ECE advice, and that inconsistencies or conflicting advice provided by different sources or by State-specific health orders caused uncertainty and confusion. Overwhelmingly, participants called for a 'single source of truth' of COVID-19 information that was up-to-date, accurate and applicable to the ECE sector.

Representatives from ECE peak organisations who were major employers of ECE staff reported a reliance on the health information released from government health agencies. However, this information was often released after work hours. The timing left little time for these organisations to prepare, translate and communicate to their educators and managers who work in the front line of ECE services, prior to the information being reported by the press. That is, these organisations set up their own lines of internal communication to their stakeholders but reported having to schedule meetings prior to work hours in order to digest the new information and determine how best to communicate this. Organisational and service-level practices had to be modified, often repeatedly, to align with rapidly changing health orders from both Federal and State governments. Timing therefore became a significant challenge, as the complexity of managing the implications of new health advice and orders caused delays in communicating the new information on to services, educators and families.

While many educators and managers reported faith in the information that came from their Approved Providers, participants reported frustration when information was not provided in a timely manner. Educators and managers also reported frustration at the release of new public health measures at middle-of-the-day daily press conferences by the Prime Minister and State Premiers together with health officials. These events placed many ECE employers and employees in the unenviable position of first hearing about new health orders from families at the end of the day. The timing of health advice therefore prevented them from fully understanding the implications of the new orders and with limited time to prepare and answer questions from families.

Finally, health sector representatives recognised the significant role that the ECE sector played in COVID-19 health messaging but recognised that a lack of two-way communication between the health and ECE sector was a barrier to the effectiveness of the communication. They highlighted that the ECE sector lacked a voice 'at the table' so had minimal involvement with public health authorities when it came to formulating and communicating health messaging that was relevant and meaningful to the sector.

4. CLARITY AND CONSISTENCY OF HEALTH COMMUNICATION

Findings from the document analysis identified a need to improve the clarity and consistency of health communication so that target audiences can understand and effectively implement health advice. Many documents directed at ECE organisations and services were composed at a reading level higher than recommended for general audiences. Furthermore, documents (particularly those associated with physical distancing, isolation conditions, and risk) often contained complex numerical information that required computation or advanced understanding beyond that recommended for general audiences. There was infrequent use of elaborative features (e.g., pictures, benchmarks, or analogies) to aid understanding. The use of non-specific numerical terms often left recommendations open to subjective inference.

Actionable information in documents was often presented with a low level of directness, thus presenting advice to services and educators in indirect and hedged language (e.g., 'may', 'might', and 'could'). This left information open to interpretation and required those receiving the information to determine for themselves which information was to be implemented as actions. Uncertainty was also compounded when instructions for

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actions differed in their level of directness within the same document.

Interviewees from Peak organisations were careful to use verified sources of information, and reported that it was their role, and the role of their organisation, to pre-empt any gaps in understanding which could be a result of language or framing. These findings were reinforced in the qualitative survey findings, where managers and educators reported that health communications were often lengthy and therefore posed difficulties in extracting the main messages for their practice. At the organisational level, interviewees experienced 'push back' from management and staff at the service level when instructions were unclear and difficult to interpret. While organisations with direct contact with government Health Departments used these contacts to clarify messages, the ability to clarify information was not available to many organisations and services. In particular, educators spoke of a lack of responsiveness from established advice hot-lines and few opportunities to interact, either with those communicating the information or with one another, in order to clarify and contextualise the information.

Documents directed at families and children were largely composed with an appropriate level of readability, and families reported that the health information received from their early childhood service was clear and effective. However, interviewees spoke of challenges in passing on written material to families who did not respond well to written documents and instead, found face to face communication more desirable and easier to understand. Compounding these difficulties was a lack of materials provided in home languages, or the challenge of communicating with families with low literacy levels. For these families, respondents explained that the relationship that they had with families formed the backbone of the face-to-face communication that they strived to supply.

5. RELEVANCE AND ACCESSIBILITY OF HEALTH COMMUNICATION FOR THE TARGET AUDIENCE

Our project identified that the content of health information and advice received by the ECE sector was often perceived as lacking awareness of, and therefore relevance to, the concerns and practices of ECE services and their educators. Across the sector, organisations, managers, and educators expressed frustration at the generic nature of the information communicated. Some advice, such as enforcing social distancing and not sharing equipment, was impossible to implement in ECE services. Other advice, such as limiting contact with educators and parents conflicted with services' philosophical and ethical approaches to interacting with, and caring for young children, families and communities. Messaging was often directed more towards school environments, leading to frustration and a perceived lack of appreciation within the sector of the concerns and practices of ECE services.

Our project found limited evidence of health communication documents for culturally and linguistically diverse families and ECE educators. Health documents that were directed towards organisations serving Indigenous or culturally and linguistically diverse communities were very long and difficult to read. This placed the burden of translation and communication onto the organisation and educators, who became reliant on culturally diverse staff members (where available) to reach out and communicate with families.

Information was often communicated in a way that was perceived as being inaccessible by the target audience. Some managers/directors and educators reported being overwhelmed by emailed information, while others reported that a lack of timely, easily accessible information left them unsure about current health orders and recommendations. Official websites tended to be lengthy and difficult to read, and provided links to other resources which added to the complexity of navigation and readability. Both educators and families appreciated opportunities to engage in face-to-face or interactive discussions about health communication content and advice, rating these as offering more understandable and clear messaging. However, while both identified face-to-face communication as the most effective communication method, educators and families reported that opportunities to engage in this way were limited.

6. EFFECTIVE COVID-19 PROFESSIONAL SUPPORT RESOURCES

Managers/directors and educators expressed a need for effective and on-going support needs. Service managers and educational leaders who reported that they were new to their role identified that there was little induction related to COVID-19. Educators did mention that professional learning modules were becoming available, but again lamented that these were often generic and difficult to apply to their own context.

Managers and educators frequently identified the importance of face-to-face or interactive platforms as a

support mechanism. Some educators in centre-based services explained that frequent discussions were scheduled when staff could interrogate and contextualise new health advice. Educators in family day care services referred to the support gained from online platforms, such as Facebook groups, which allowed them to pose questions and gain responses from other family day care educators. Those in larger organisations appreciated online zoom seminars led by organisation leaders, but recognised that those in smaller organisations or stand-alone services missed out on the benefit of such resources.

Finally, the general high (i.e., difficult) readability level of many COVID-19 documents provided by both the health and ECE sector identified a need for professional development and support in the production of clear, consistent and actionable health messages

RECOMMENDATIONS AND BEST PRACTICE MODEL

In this section we present seven broad recommendations aimed at establishing a Best Practice Model of health communication that derive from the major findings of our research. These recommendations are based on the value of a productive and mutually beneficial collaboration between the ECE and Health sectors, which we believe will strengthen any future health communication efforts. Indeed, effective communication between health and early childhood education is increasingly being recognised as essential to support children and families in the early years. For example, the NSW Government, under its Brighter Beginnings Initiative is working towards an integrated approach to conducting children's development and health checks, and to ease referral pathways for families (<https://www.nsw.gov.au/initiative/brighter-beginnings>). This approach will require improved communication that will only be possible through systemic changes. The recommendations are also presented in the context of action taken by Minister Aly, the Federal Minister for Early Childhood Education, to establish a National Early Childhood Education Strategy for Australia, which presents opportunities for National consolidation of ECE-specific health communication policies and procedures.

Arranged under four broad themes emerging from the key findings of our research, we present seven recommendations for consideration together with potential strategies for actioning these. This section concludes with our proposed Best Practice Model that we believe will provide a conduit for the delivery of the recommendations.

THEME1: STREAMLINE AND COLLABORATE

Recommendation 1. Establish a national pandemic and health-crisis response strategy for the ECE sector to support consistency in pandemic management policy and procedures, as well as health messaging and advice throughout the country.

Our findings strongly indicated a need to develop a national pandemic and health crisis response strategy for the ECE sector in order to reduce the occurrence of conflicting advice and strategies between jurisdictions, and instead provide a more streamlined national approach that is coordinated by government and includes input from ECE sector. A national response will inform the development of relevant organisational and service-level pandemic response plans, policies and procedures. This response strategy will generate the communication infrastructure necessary to develop Australia-wide policies and procedures in the event of future pandemics or public/ environmental health crises that are the timely, sector specific and consistent in circulating public health information. A National ECE response strategy will also establish provision for localised infection prevention strategies when the need arises, but will do so within the agreed upon National strategy.

Recommendation 2. Increase representation of, and collaboration between the Health and ECE sectors at regional, State and Federal levels by including ECE representatives on advisory boards and committees.

Our findings identified a clear need and desire for increased reciprocal communication and collaboration between the ECE and Health sectors. This recommendation can ensure that, during a pandemic or other health crisis, sector specific advice and information is provided upstream and downstream by trustworthy authorities in Health and ECE. Establishment of joint advisory boards and committees on public health can be mutually beneficial in planning and co-designing effective communication strategies that are responsive to the interests and concerns of the ECE sector and their communities. Cross sector representation and collaboration will enhance bidirectional communication between the ECE and the Health sectors, which will ultimately raise

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awareness and improve community-wide communication informed by sector-specific concerns, practices and needs.

THEME 2: RESOURCE

Recommendation 3. Develop easy to access, read and understand health related resources needed by ECE service providers, staff, families and young children, to support actionable responses to health emergencies.

Our findings indicated that many organisations were overwhelmed by the task of having to interpret health advice and develop a variety of resources appropriate for use by staff, families and children. Providing national funding to develop and maintain a national bank of ECE health-communication resources will reduce the burden on organisations and services in the sector having to create their resources for staff and families. These resources may be used directly by organisations and services or may be adapted to suit their particular local context, service type (centre based, family day care, out-of-school-hours care) and communities. Adequate funding is also necessary to ensure that these resources are translated accurately to community languages and tailored to suit diverse populations including Indigenous families, and regional and remote communities.

THEME 3: CONTEXTUALISE AND SUPPORT IMPLEMENTATION

Recommendation 4. Allocate funding for local health brokers, who will guide the implementation of health advice.

It was evident from our findings that the uptake of health advice was facilitated well when ECE or Health organisations provided advice and support about how to apply health recommendations and orders within their local ECE communities. Health brokers, whose role it is to provide direct advice to ECE services to implement health orders and communicated advice, will provide the localised support that many in the ECE sector felt was lacking during the COVID-19 crisis. Health brokers will be known to and trusted by the ECE communities that they service, and could be employed by employer groups or collectives, or by local health districts or community agencies. The funding of these roles will reduce health communication barriers by providing practical advice to ECE services on how to implement health advice at their local level.

Recommendation 5. Establish systems for ECE localised face-to-face and/or online platforms for families and educators to provide interactive opportunities that are responsive to current and emerging local challenges and questions.

Our research project indicated that staff and families were able to better interpret, contextualise and implement health advice when they had opportunities to discuss this advice with each other. Educators and families espoused the benefits of ECE-specific face-to-face meetings and discussions as well as online webinars and social media groups that provided support and opportunities to share concerns. Our data suggest that during lockdown periods, these systems reduced the feelings of isolation and anxiety and fostered a sense of collective efficacy among educators. Interactive communication, whether face-to-face or on an online platform therefore has the potential to:

- a. foster better clarity about health information and advice provided to the ECE sector;
- b. support managers and educators to contextualise general information and to determine how best to implement this within their services and communicate this to their family communities; and
- c. enhance the identification of roadblocks or localised issues that are limiting the effectiveness of health communication and advice so that these challenges can be addressed at a local level.

THEME 4: BUILD CAPACITY

Recommendation 6. Deliver professional learning modules to improve the individual's capacity to understand, implement and communicate health advice.

Our findings indicated that the ECE sector will benefit from health communication professional learning programs that are specifically tailored to address ECE sector's challenges, concerns and practices. Freely available, easily accessible and accredited professional learning modules will enhance the preparation,

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willingness and capabilities of ECE managers and educators to implement effective health messages within their services and to their family communities. Modules are needed to cover the following topic areas:

- a. How to judge the quality of health information and where to access trustworthy health information and advice.
- b. How to foster the collective efficacy of educators in terms of their ability to ‘make a difference’ in supporting the health and wellbeing of children, families and colleagues during times of a public health crisis.
- c. Practical strategies to better communicate health advice effectively to stakeholder children and families.
- d. How to develop effective localised health communication plans and strategies for staff, families and children.

Recommendation 7. Provide professional learning to upskill content producers who create health communication documents and resources to improve the readability, interpretability and overall effectiveness of health communication that is accessed and created by the ECE sector.

Our research project identified that much of the health communication information that was provided to, and created by, the ECE sector was written for those with abilities above the suggested reading levels (grade 6-8), making the content ‘(very) difficult to read’. Interpretation of numerical information often required some inference or analysis, making it challenging to understand and put into practice. Advice on health-related actions was often hedged which left its implementation open to mis/interpretation. The effectiveness of health information produced by and for the EC sector could be therefore improved by:

- a. Upskilling content producers in the concept of readability and targeting all produced materials to appropriate reading levels (grade level 8 or below).
- b. Rethinking the use of hedges and overall clarity of numerical concepts in health advice in relation to the ease and requirement of their implementation.
- c. Shifting towards a greater focus on multi-modal communication strategies to support readability, ease of understanding and communication of numerical concepts.

A BEST PRACTICE MODEL OF HEALTH COMMUNICATION

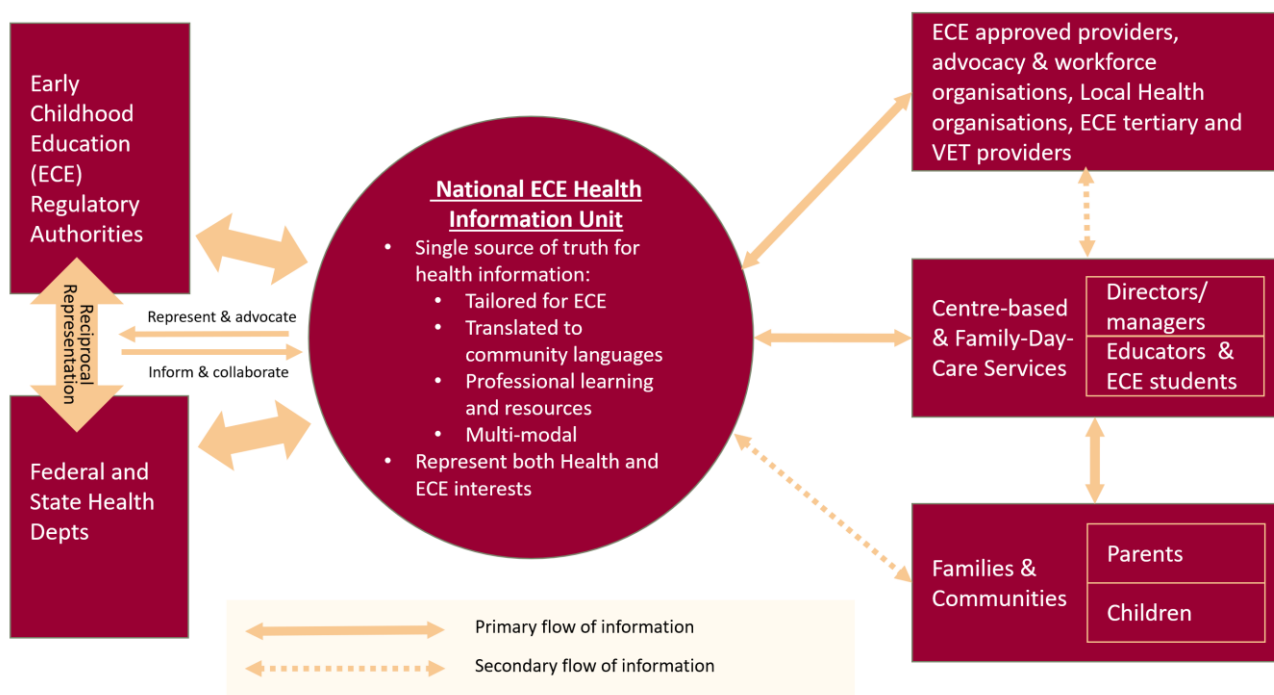
Based on our research findings and the seven recommendations above, we recommend a Best Practice Model of Health Communication that involves the establishment of a National Early Childhood Health Information Unit (ECHIU). This entity will assume a health broker role, serving as a mediator between Government Health departments and ECE regulatory authorities, and sector specific organisations and services. The role of the ECHIU is to facilitate the two-way communication of information between those issuing health orders and advice and the ECE sector, at organisational, service and individual levels. The ECHIU will therefore be staffed by individuals who collectively hold health, ECE and health communication expertise.

The ECHIU would sit independently without any specific employer group or management affiliation yet would be respected and trusted within the ECE sector as the ‘source of truth’ for public health information. This unit would include experts in the system and practices of early child education and in public health and health communication, and its role would be twofold:

- iii. To receive and translate up-to-date health advice and information from Government health agencies so that it is accessible, clear and relevant for the ECE sector.
- iv. To represent and advocate for the needs and concerns of the ECE sector to Government health agencies.

With its ability to represent both the Health and the ECE sectors, the ECHIU will establish and communication a national pandemic response strategy (**Recommendation 1**), and the resources needed by the sector to implement that strategy in their localised contexts. This model of health communication is illustrated in the Figure 3 below:

Figure 3: Evidence-informed best practice model of health communication



To ensure the trustworthiness of the health advice and to be able to situate this within the ECE regulatory context, the ECHIU will be in direct contact with the Federal and State health departments and the relevant ECE regulatory bodies. To facilitate this mutual influence, we recommend that reciprocal representation between these two governing bodies is increased (**Recommendation 2**) in order to raise mutual awareness across the two sectors.

The ECHIU will create health information resources that are easy to access and understand and are tailored to

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the needs and practices of the ECE sector and the communities that they serve (**Recommendation 3**). While being vital during health crises, the role of the unit could be on-going, providing up-to-date evidence-informed health information and resources to cover the large array of health and hygiene topics that ECE organisations and services have to deal with on a daily basis. By being agile and responsive to current health needs, the Unit would replace printed text resources such as the NHMRC ‘Staying Healthy’ guide. Our recommendation is that the ECHIU Unit communicates health information directly to the ECE sector through the provision of an agile web-based platform site which contains up-to-date, evidence-informed information and advice and downloadable resources that are tailored towards the ECE sector needs and concerns. Organisations including particular employers or representative groups, local health and community support agencies, tertiary providers and services can access information from the ECHIU, reducing their need to create their own resources. Educators will also access health information directly from the ECHIU, and obtain resources (including translated and culturally-sensitive ones) that can be used directly with their child and family communities.

The freely available resources can be accessed by localised funded health brokers who can use them to create community -specific resources which will aid the implementation of the health guidance in their service-level and family stakeholders (**Recommendations 4 and 5**). Being at the ‘coal face’ of the implementation of health advice, these funded brokers can feedback information relating to localised enabling and constraining factors to the ECHIU, who can update their resources and make representations to the Health and ECE governing bodies accordingly.

The ECHIU will also develop and deliver free and accredited professional learning modules aimed at building the health information capacity of the ECE sector (**Recommendation 6**). With expertise in health communication, the ECHIU is also able to build the capacity of those producing health communication documents at both governing body and local levels (**Recommendation 7**) as well as ensure that the documents provided within the ECHIU itself meet the World Health Organisation guidelines for effective and actionable health communication.

SCALING UP THE MODEL

While the best practice model was developed in response to the ECE sector’s experiences of COVID-19 health communication, we propose that this model could be scaled up to be a responsive and effective communication model in the event of any crisis impacting the health and safety of young children and their families (such as bushfires, floods, and droughts) in ECE services, and the community that the sector serves. The resounding finding of this research project is that the ECE sector exercises a strong and resilient ethic of care towards their family and staff communities, and take seriously their role in maintaining the health, safety, and wellbeing of their communities. With the appropriate support recommended in this report, it is clearly possible to harness the potential of the ECE sector to be an effective and trusted communicator in the face of future health or safety crises.

THIS PROJECT WAS A COLLABORATION BETWEEN:



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