The Leadership Role of Australian Early Childhood Education Organisations in Communicating Health Information during COVID-19: Lessons from Elite Interviews

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Abstract

During the COVID-19 pandemic, early childhood education (ECE) organisations had to source, evaluate, and communicate information effectively, and implement appropriate strategies and processes to keep children, families, and educators safe. Based on a knowledge brokering perspective of health communication, this chapter reports on an Australian study that investigated the leadership role of ECE organisations in communicating health messages. Thematic analysis of twenty elite interviews with leaders in ECE and health organisations identified five overarching themes: (i) roles and responsibilities in communicating health messages; (ii) sourcing and assessing health information; (iii) communicating health information to ECE services; (iv) factors influencing effective communication; and (v) resources needed to communicate effectively. Overall, the study findings demonstrate that ECE organisations are willing and able to communicate health messages, but they require consistent, timely information that is accessible, from “one source of truth”, specific for the ECE sector, and contextualised for different service types and geographic locations. Closer engagement between the health and ECE sectors, contextualised health information, and adequate leadership support and resourcing, are required to sustain effective public health messaging within the ECE sector.

Key Words: health communication; elite interviews; knowledge brokering
Introduction: Australian context

Australia has had one of the world’s most effective management strategies of the COVID-19 pandemic (Blau and Tonkin 2021). When compared with other developed countries, through strict government interventions – such as international and state border closures, mandated mask-wearing, restrictions on travel, limits to crowds, extensive lockdowns in areas with high COVID-19 cases, and high levels of vaccination – the rate of infection and deaths from COVID-19 remained relatively low in Australia in 2021. Nevertheless, as in other countries (Atiles et al. 2021), COVID-19 has had a huge impact on the early childhood education (ECE) sector throughout Australia.

In Australia, ECE services (that is, services where children receive early childhood education and care) are recognised as serving the dual purpose of supporting parents’ workforce participation as well as educational and social outcomes for children. During the height of the COVID-19 pandemic, the Australian Government announced that the provision of ECE was an “essential service” (Parliament of Australia 2020). Thus, the majority of ECE services across Australia remained open – closing only when there were cases of COVID-19 within the service, or when operational issues, such as staff shortages, created non-compliance and viability problems, forcing services to close.

Several research projects have been conducted on the impact of COVID-19 on the Australian ECE workforce. Logan et al. (2021), for example, in a study of the ways ECE service providers supported educators’ well-being during the pandemic, found that both leaders and educators had strong feelings of betrayal by policymakers, unions, and governments. Other studies have shown that staying open during the pandemic increased the workload (e.g., intensified cleaning requirements) of Australian educators (The Front Project 2020), increased their stress, and negatively impacted their psychological and physical well-being (Eadie et al. 2021; McFarland et al. 2022; Quiñones, Berger, and Barnes 2020). One of the major causes of concern for educators was the uncertainty surrounding COVID-19, due to what educators considered to be poor or unreliable communication of public health information (McFarland et al. 2022).

Despite widespread COVID-19 restrictions and lockdowns, such as school closures and work-from-home orders for the general public, ECE services in Australia remained open. As they continued to operate during the pandemic, educators in ECE services had to rapidly and appropriately respond to health messages, and implement changes to their practice to keep children, families, and other educators safe. Health information needed to be accurate and unambiguous, and communication pathways had to be efficient (Harris and Dakin 2021). It was the role of public health officials in each state/territory to formally communicate health messages. Leaders within services and/or within
ECE organisations that either provide and/or support ECE services and educators, were responsible for sourcing, evaluating, and communicating health information effectively to educators and families, and for ensuring that appropriate strategies and processes were implemented every day. The focus of this chapter is the leadership role of ECE organisations in communicating public health messages to educators, children, families, and communities.

The role of health and ECE organisations

The role of Australian health and ECE organisations to communicate health information must be considered within the context of our unique geography and federated system of governance and healthcare delivery. Australia is the world’s sixth largest country, and its governance is divided into eight jurisdictions comprising six states and two territories. While most Australians live in the major cities of each state/territory, there are significant rural and remote communities scattered unevenly across the country. As a mixed economy, health and ECE services are delivered through a combination of both public and private providers, with funding and responsibility for legislation and regulation divided between federal and state/territory governments.

Nationally, the Australian Government Department of Health was charged with the central role of providing medical and public health information about COVID-19. At the height of the pandemic in 2020, the Australian Chief Medical Officer stood side-by-side with the Prime Minister of Australia to provide televised daily updates on COVID-19, especially on federal policies such as border closures, primary care responses, and the procurement and roll-out of vaccines. This daily duet of presenting scientific evidence-based health information together with political leadership was also replicated at the state/territory levels. Subsequently, the Prime Minister also convened emergency meetings with the State Premiers and Territory Chief Ministers, leading to decisions about matters such as ordering vaccines and setting a staged and prioritised vaccination roll-out plan.

As the pandemic advanced and impacted on the states and territories to different degrees – thus requiring different responses – the fragmentation between federal and state/territory government systems and communication methods started to buckle under pressure. State and territory political and public health officials made swift, strong, and decisive responses to the COVID-19 crisis based on the best available information and identified needs in their own jurisdiction. This led to significant variations in public health orders, border closures, venue-capacity restrictions, and mask-wearing orders across the eight jurisdictions (Stobart and Duckett 2021).
In Australia, the ownership, management, and funding of ECE services are highly diversified (Australian Children’s Education and Care Quality Authority [ACECQA] 2022). Services vary in terms of type (e.g., long day care, preschool, family day care, and outside school hours care); ownership, finances, and governance (e.g., large and small not-for-profit and for-profit organisations, small business, and community owned and operated); size (e.g., number of staff, children, and families); quality (as assessed by national standards); and location (e.g., urban, regional, or remote). Australian public schools are primarily funded and regulated at the state/territory level and are compulsory educational settings for children aged five to seventeen years. In contrast, most ECE services cater for children from birth to five years of age, and come under national legislation (ACECQA 2022).

A knowledge brokering model of health communication

ECE services routinely receive health information from public health authorities in their state/territory. This information mostly relates to outbreaks of infectious diseases. An efficient and effective knowledge brokering system facilitates the reciprocal transmission and translation of information to the benefit of both partners (Dagenais, Laurendeau, and Briand-Lamarche 2015). In situations where communication is about risk and risk prevention, two-way communication which is honest, transparent, and based on mutual respect is particularly critical (Leask and Hooker 2020). In a bi-directional knowledge brokering partnership between the health and ECE sectors, evidence-based health information needs to be communicated to and through the multi-level ECE sector, to ultimately reach services and inform educators, children, and families. Reciprocally, these stakeholders’ goals, concerns, and information needs are then communicated back through each level, ultimately reaching health agencies and policymakers. Translated to the Australian ECE context, a partnership communication model between the health and ECE sectors that reflects bi-directional knowledge transfer is represented in Figure 1. As will be shown in this chapter, the complexity of this system created a challenge for public health communication within the ECE sector during the COVID-19 pandemic in Australia.
The study

For the study presented in this chapter, we partnered with twelve ECE organisations in Australia to investigate the effectiveness of health messaging to the ECE sector, and the factors that can maximise the effectiveness of the health information and its uptake. The overarching project was a large, multi-tiered, mixed-methods study that included document analysis, survey questionnaire, case studies, and elite interviews. In this chapter, we share findings from the elite interviews, conducted to address two research questions (RQs):

- **RQ1**: What health information is received, sought and communicated by the health and ECE sectors in order to minimise the chance of infection of families and staff?
- **RQ2**: How does the ECE sector communicate health information to staff, families and children?

Methodology

Elite interview (Dexter 1970/2006) methodology is grounded in the qualitative theoretical perspective of social constructionism. Elite interviews distil specialised knowledge and views (Dexter 1970/2006), in this case relating to the development and dissemination of health information to ECE services. Ethics approval was applied for and received from the lead university, and interviews were conducted with four representatives from key health agencies and twelve representatives from ECE organisations. The ECE organisations were ECE peak bodies, ECE employer organisations, and advocacy organisations with a
remit for providing professional support to ECE services. Combined, they have reach across Australia. These organisations were identified from the research team’s extensive knowledge of the Australian ECE and health sectors, and they reflect the kaleidoscope of stakeholders involved in managing the response to the COVID-19 pandemic in Australia. Informants for the elite interviews were individuals in a senior position (e.g., Chief Executive Officer or District Manager) with responsibility for the development and dissemination of health advice and information to ECE services, educators and other staff, and/or families and communities, during the COVID-19 pandemic.

Potential interviewees were contacted by a research team member by email or phone. For those individuals who gave informed consent to participate, interviews lasting up to one hour were conducted via video link and audio recorded. Interviews were completed in 2021, while Australia was experiencing the Delta variant of COVID-19. The semi-structured interviews were guided by overarching questions related to the type of health information interviewees 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. Audio files of the interviews were transcribed, and the transcripts were sent to participants for checking. The returned “approved” transcripts, consisting of 211 pages, formed the corpus for analysis.

Analysis

The elite interview analysis used an inductive analytical approach consisting of coding and thematicising (Denzin and Lincoln 2017). Initial coding of two transcripts (one health; one ECE) was conducted by the second author using the NVivo software package. This identified 137 unique codes. Three authors then checked the coding until there was agreement. They then double-coded four transcripts using the existing codes to check consistency. There was strong agreement on these codes, with NVivo reporting Kappa coefficients of 0.67–0.87 which is fair–excellent (McHugh 2012). Coding was continued by the second author, using an inductive–deductive approach according to the code book, while inductively identifying additional codes to capture further nuanced meanings (Xu and Zammit 2020). Additional codes were especially needed when analysing responses from informants in the health sector. This analysis was performed by an author with deep insight into and understandings of the health sector contexts, and the additional codes were cross-checked and agreed with the first author. At the end of coding, a total of 206 codes were identified. Next, these codes were organised into themes.
Results

The coding process resulted in five major interpretive themes from a practical stance of the project. As discussed below, these themes reflect the potential for practical application of our findings in improving future practice in health communication during a pandemic or any other national health crisis.

Theme 1: Roles and responsibilities in communicating health messages

The first theme is related to what interviewees considered were the roles and responsibilities of ECE organisations in communicating health messages to the ECE sector. Overall, interviewees saw their organisation’s role in communicating information to be that of providing accessible, credible information, which filled information gaps needed by ECE services. For the most part, this supported the educators but also informed the wider community.

Accessibility of information, in terms of the audience’s ability to understand it, became important because of a mismatch between the linguistic level of provided information, and the level of understanding of educators and families. Rather than simply passing information on, interviewees felt that it was their role, and the role of their organisation, to pre-empt any gap in understanding which could be a result of language or framing. For example, one participant noted:

Also really trying hard to make the communication straightforward so not lots of waffling bureaucratese. I can’t stand that when people are ‘actioning things’ and all that kind of stuff and there’s ‘key takeaways.’ It makes no sense to people, so being really clear, saying, ‘We’re going to start closing at 4 o’clock from this day. Here’s why we’re doing this.’

We will return to this point later.

Many of the interviewees also mentioned that their goal was to provide credible and meaningful information for the ECE sector, and this primarily meant sourcing information from the government and passing it on accurately. Respondents were careful to use verified sources, to validate information, and to provide links and sources when communicating it to others.

However, the necessity of providing credible information did not outweigh the need to fill gaps from information sources. At times this meant sourcing additional information and/or making additional decisions for the specific needs of their service context, such as long day care, family day care, preschool, or outside school hours care.

An additional subtheme mentioned in the interviews was the importance of taking on an additional advocacy role for the ECE sector, and communi-
cating information back up the leadership chain. In most of these cases, these roles were informal or in addition to formal advocacy roles held. As one participant noted:

So you’ve moved into this spot of trying to advocate on behalf of the sector because it became apparent the people who were supposed to be helping us, had no idea about us. And, in all honesty, their primary focus was on aged care. The only reason – because they were having fatalities – the only reason there was a focus on us was because they needed to keep us open in order to keep the economy stimulated, and parents continuing to work.

We also found interview comments which referred to the need to press government agencies for more information, faster, and to stay continuously visible so that the sector was not forgotten during future public health crises impacting young children and their families. While some interviewees had advocacy as part of their substantive organisational role, the pandemic increased the time and focus that they placed on this aspect of their role. They noted that they expanded the number of organisations and government departments that they engaged with, as well as the number of contacts in those organisations.

**Theme 2: Sourcing and assessing health information**

A second theme relates to how ECE organisations sourced and assessed health information. Interviewees received information from a broad range of sources, but generally the most significant were the federal and state/territory government departments of health and education. This meant that each person received formal information from at least four sources, plus a variety of sector, organisational, and individual sources such as peak bodies, other federal health agencies, professional organisations, networks, and personal contacts.

As previously mentioned, the interviewees did not simply pass on all the information they received, but rather they assessed it against the needs of their services and community. One major criterion they used was how relevant the information was to their context. Unfortunately, in almost all interviews, respondents discussed the lack of information specific to the ECE sector and the different service types within the sector, as noted above. For instance:

Interestingly, in relation to early education, they weren’t saying much at all, and one of the big problems for early education, was that they were very clear about what to do in schools and a lot less clear about what to do in ECE centres [services].

The second missing contextual piece was that of location. A lack of specific information for the interviewee’s location was mentioned at the level of state/territory-based information. For example, when one state/territory had implemented specific ECE restrictions, others had not. This pattern was also
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noted at the level of city and rural locations, and COVID-19 hotspots versus general rules and restrictions. As one participant stated:

If they can’t get contextualised information that applies in their jurisdiction or their local area in a timely manner, then that would impact their ability to provide that service. And I think that’s probably one of the core gaps where information’s coming out from health departments, and there would be – and understandably so – there would be a time lag between when that information was contextualised to different service types, or to the ECE sector as a whole.

Another challenge was the difficulty of finding information, especially when it came from multiple sources and things changed quickly. The diversity of sources resulted in many interviewees calling for a single repository of information which was up to date and targeted at ECE contexts. The following statement was typical of many:

What we really wanted was to have a single source of truth around early childhood education and care, and AHPPC [Australian Health Protection Principal Committee] did put up a specific early childhood piece of advice, which was really, really valuable which became a source of truth for providers. But then each jurisdiction unhelpfully unpacked that slightly differently and at times used different language to each other. It was very intense.

The need for a “single source of truth” was also related to the interviewees’ struggle with inconsistent information, which required ECE decision-makers to rule on which source of information to follow. Because of the lack of detailed information, and state/territory-based inconsistencies, this resulted in ECE organisations having to modify internal policies and procedures to align with the rapidly changing public health orders from federal and/or state/territory governments. At times, these modifications happened several times in the wake of a single public health order as finer details and specific contexts were discussed and confirmed for ECE services and organisations.

Further factors which hindered the smooth processing of information by the interviewees’ organisations included missing information pieces which could have enhanced understanding. Of foremost importance was the missing justification for why there was such a difference between the expectations of schools and ECE services, the latter of which remained mostly open throughout the year. The lack of ECE sector-specific information led to a lowering of trust in government-supplied information, and affected the implementation and understanding of each media release. Typically, these either ignored the ECE sector, responded to it only briefly or contradicted recommendations targeting school settings. One participant said, for example:

I think what would have been particularly helpful is some additional explanation as to why things were different for different sectors – so, for example, schools which are virtual classrooms and yet early childhood services had to stay open. Why was that health information different? Is it that they didn’t perceive that early
childhood education and care could happen from a home distance learning perspective? Or is it that the two professions are valued differently? Or is it that the health advice was different?

Specific details of practical information that was missing included definitions of terms such as “essential worker”. The meaning of this term varied throughout the pandemic. Also missing were explanations of new terminology such as “deep cleaning”, as was referred to in this quote:

The Department of Health didn’t have clear guidance on what types of cleaning were required. The Victorian Government and the AHPPC were referring to this notion of deep cleaning for a while, for which there was no technical definition, and no sense of … what did deep cleaning require? Could educators do the clean? Did you need a certificate? All those sorts of technicalities caused a whole raft of queries for us for a number of weeks as we had services that needed to be shut and have cleaning done.

**Theme 3: Communicating information to ECE services**

The third theme relates to how ECE organisations communicated information to ECE services. Once COVID-19 information was received and processed, people from each ECE organisation then sent that information to their staff, families, and broader community. While social media, emails, and websites were the primary means of communication, twenty-seven different communication methods in total were identified during our interviews.

Interviewees were clear that they had considered many factors in communicating their messages to ECE services. Of the most often mentioned, three factors map directly onto the challenges they faced with received information. The first was considerations other than audience, such as location-specific information and timing of information. Timing was a particular challenge, as information was often slow to filter down through different levels of each organisation, and it was also slow to be approved by management to be sent to educators and families. One participant said, for instance:

…we’re a national [organisation], and we have centres in all states, so we have to have a national response. So it became not helpful because they didn’t consolidate what was happening at each state level. So the job was made twice as hard because you had to read up what each state was doing, and then come up with an appropriate response either for the entire national network, or for Western Australia versus other states, or Victoria, or whatever that looked like.

The second factor was how the messages were tailored for the different audiences. Most interviewees discussed culturally and linguistically diverse (CALD) audiences as the main reason for tailoring information. Additional reasons included tailoring information for educators versus families, for families of essential workers versus other families, for educators with specific
needs, and for different types of ECE services such as family day care. In many cases, tailoring information for CALD audiences was done directly by the educators themselves, acting as informal translators and interpreters. As this participant explained:

We have a very diverse centre team as well who obviously have to communicate to families and children, as well as their peers, and I’m aware that our centre teams who are bilingual, did an incredible job of explaining what was going on in those contexts. Like for people who didn’t understand what was going on. And that still gives me goosebumps. They took that ownership over themselves for their families and children to explain what was going on. Which is amazing.

Third was the consideration of what kind of information was needed and transforming the received information in some way, such as combining sources, adapting language for accessibility, adapting information to highlight the actions which needed to be taken, and adapting for the ECE service context. This participant explained their process for sharing this information as follows:

I had tables, Excel sheets, basically, with advice from different places, and members would come to me with questions. … and then we then had to step it out and create processes for our members to easily understand what they should be doing, whereas there was just no detail in any of the information we were given about any of that.

Theme 4: Factors influencing effective communication

The fourth theme emerging from our findings relates to factors that influenced ECE organisations’ capacity to communicate information. At the organisational level, interviewees spoke of several challenges which impeded the effectiveness of communication. In identifying those factors, interviewees explained the pushback that occurred, reflecting disagreement on decisions from management and from staff, particularly where instructions from health authorities were unclear and interpretation was needed. There were also many comments regarding the struggle of balancing communication needs with educators’ usual daily work demands, and continuously implementing COVID-19 safe practices.

From the perspectives of our interviewees, as has been found in other studies (Eadie et al. 2021; McFarland et al. 2022; Quiñones, Berger, and Barnes 2020), the primary factor which influenced educators’ understanding of messages was stress and anxiety about the pandemic, augmented by the uncertainty of public health communication, and future funding of ECE services. For educators, the conflicting requirements and priorities of work and home were also a barrier to acting on information effectively. One participant commented:
We were kind of having to make decisions ourselves, so try to balance continuing to operate with ensuring that particularly our teams could manage the risks for themselves and for their own families.

While there were other factors for families and at the broader political level, the key factor which influenced people across the ECE sector was the importance of cultivating, or already having, firm trusted relationships, both up and down the lines of communication. For the elite interviewees who had contacts in government departments, response times were faster, they were able to get information clarified better, and they could ask more questions and even set up meetings and webinars for their staff. For families, the pre-existing strong relationships between families and educators meant that educators were thought of as reliable sources of information. For educators, to retain this trust and credibility, it was imperative that they had a thorough understanding of the pandemic health messages, so they were able to respond to parents’ questions.

The importance of these relationships was also highlighted by the interviewees in regard to the ways their organisations preferred to communicate — while most communication was online, educators themselves spoke in person to families in their centres, and management spoke in person to educators in their centres. Both strategies were highly appreciated and selected as the modes which got the most positive feedback. This interviewee, for example, explained how their organisation met the communication needs of CALD families as follows:

We find that families often don’t want — they don’t respond well to the piece of paper, to hand them a piece of paper. And I suspect that is probably why, that even those translated documents are still difficult for them, whether they’re literate or not. And … if that’s then pitched at a higher level of language development or language skill, even in a home language, then perhaps that wasn’t accessible to them. So we find that a majority of what we do with our families is verbal.

**Theme 5: Resources needed to communicate effectively**

The final theme relates to the resources that ECE organisations need to communicate information effectively. ECE organisations drew on a wide range of resources to keep up with the flow and demand for COVID-19 information by staff and families in their services. Most large ECE organisations relied on a dedicated communications person or even a team of communicators who were able to source, interpret, write, and distribute information. In many cases these individuals or teams were formed in response to the COVID-19 crisis and did not exist beforehand. This meant that people were redeployed into communication roles or had communication roles added to their regular roles in order to keep up with the demand. As one participant shared:
I can honestly say that I never thought in my career that I would be doing what I’ve had to do in the last eighteen months. The steepest learning curve ever when, you know, the buck stopped with me until that new person started three weeks ago.

This demand also meant that many staff in ECE organisations went above and beyond in terms of their regular working hours. Interviewees themselves often took on this role, and they also acknowledged other staff who took on additional work, and this time was often unpaid. Working outside of normal hours was particularly important due to the timing of announcements that were made. Often, these announcements were made in the evening or on a Sunday and needed to be implemented by 9am the next day. For example:

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. And then I would meet with one of my team at 7, my 2IC [second in command].

Finally, interviewees acknowledged the commitment and extensive efforts by educators and other staff in a variety of roles, but especially in translating and interpreting messages for CALD families, often unprompted. This role was especially important because of the prevailing trusted position held by educators with families. That is, trusted to care for their children, families also tended to rely on educators as a source of credible information during the pandemic.

Views from the health sector

Accessing health sector officials for interviews in our study was difficult due to continuous demands on their expertise and time. In the context of the pandemic where health officials were focused on timely and comprehensive responses to the impacts of COVID-19 on health services and the health of the population, this was not surprising. Nevertheless, important themes emerged from four interviews that were completed, as discussed next.

During their interviews, the health officials identified a lack of two-way communication with the ECE sector. They confirmed that the ECE sector lacked “a seat at the table” at high-level government meetings when it came to formulating or conveying health messages about COVID-19 to ECE services. They also mentioned the highly hierarchical and fragmented nature of government organisations and their responsibilities. For example, some health department officials stated that relevant information was passed to the Department of Education for distribution to schools. Any further decisions regarding distribution beyond schools were at the discretion of the Department of Education. Health officials recognised that there was little specific consideration of the communication needs nor the specific contexts of the ECE sector when developing communication strategies about COVID-19.
Despite this one-way communication from health officials to the ECE sector – but not the other way around – all health officials interviewed recognised the importance of the ECE sector to provide wide reach to families. They acknowledged their need to better understand the ECE sector and its health communication needs, by reinforcing the importance of finding ways for the health and ECE sectors to work more collaboratively.

Conclusion and policy implications

Our research captured the perspectives of elite informants from ECE and health organisations, performing leadership roles in public health communication during the COVID-19 pandemic in Australia. The study is limited by the number of participants and its geographical specificity and is therefore not generalisable. Nevertheless, our approach, based on elite interviews, is an international first in being able to reflect on one country’s response at a macro level, demonstrating the complexities of public health communications to and from the frontline of service provision involving children and adults.

This project has highlighted how during COVID-19, leaders in ECE organisations played a pivotal role in accessing, collating, translating, and disseminating public health information that was meaningful for the specific needs of the end-users – be it children, parents, or educators. At the frontline of service delivery, educators, parents, and children were ready to take action, but they wanted to receive clear and consistent directives from sector leaders.

We found that despite the strong advocacy role played by the ECE organisational leaders in this study, there are some fundamental challenges in health communication between the ECE and health sectors. From a knowledge brokering perspective, health communication is most effective when it is reciprocal (Dagenais et al. 2015), honest, transparent, and based on mutual respect (Leask and Hooker 2020). There is no doubt that the complexity of the Australian ECE sector created a significant challenge to two-way communication of health information during COVID-19. This study has highlighted the faultlines of public health communication, emerging through the fragmentation of political and professional structures, overlaid by geographical distances and demographic diversity. Moreover, the role and capacity of each ECE service to provide accurate, relevant, and just-in-time information about COVID-19 to its educators and other staff, children, and families varied according to factors such as service type, ownership and governance, size and quality, and finances and location – in an urban, regional, or isolated rural community.

A pandemic does not discriminate. Therefore, it is imperative to establish a nationally consistent systemic response in improving communications to and from the ECE sector to health and other areas of government involved with
young children and their families. It is evident that a new model of public health communication between governments and ECE is required to better address the complexities as discussed in this chapter.

Specifically, our research indicates the power of the ECE sector to perform the role of a knowledge broker between the health and ECE sectors. By aggregating and contextualising critical health information appropriately for the ECE sector, the health and well-being of young children, families, and educators can be improved for the benefit of the wider community.

References


