Healthy eating and physical activity in early childhood services:

Enhancing policy and practice in Victorian family day care and long day care

A report to the Eat Well Victoria Partnership

July 2003

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Please note that this document is a report to the Eat Well Victoria Partnership
and does not necessarily reflect the views of member organisations

Preface

We are currently facing a major public health problem in Australia in the form of increasing rates of overweight and obesity. This problem has negative implications for associated conditions such as cardiovascular disease, diabetes, some cancers, gall bladder disease, psychosocial and musculoskeletal disorders. Poor nutrition and physical activity habits underpin the weight gain and associated disease trends. As a consequence, rapid rises in direct and indirect health costs are likely for individuals, the community as a whole and the government. Of particular concern is the increasing rate of overweight and obesity amongst young children. As current trends look set to continue, action is imperative.

The Eat Well Victoria Partnership is well placed to contribute to the action. In 2002, the Partnership determined that promotion of healthy eating and the prevention of overweight and obesity in children in organised settings was a priority and that a public health approach involving policy and organisational change was essential.

This policy analysis paper was commissioned by the Partnership to inform our advice to key stakeholders with an interest in public health nutrition and physical activity options for children in Family and Long Day Care. It also serves to underpin the work of our member organisations in government, non-government, educational and professional organisations. The Victorian Health Promotion Foundation provided the funds for the policy analysis project. Both this report and its predecessor (*Public health nutrition policy in organised settings for children aged 0-12: An overview of policy, knowledge and interventions*) can be viewed on the VicHealth website at www.vichealth.vic.gov.au.

We believe this report makes an important contribution to current national and state discussions about nutrition, physical activity and the achievement of healthy body weight for young children. The report identifies actions that are required to ensure that Family and Long Day Care programs can support children and their families to eat well and to be active. The content reaffirms the Partnership's position that improving children's nutrition and physical activity patterns is essential and that focusing on organisational policy and regulatory development is vital.

We commend this report as an important source of information that will assist us to ensure the health and wellbeing of young Australians.

Robyn Charlwood
Chair, Eat Well Victoria Partnership

Acknowledgments

Many organisations and individuals have provided essential support and guidance to this project in a range of different ways including professional, practical, financial and moral support. The Appendices to this report contain details of all the participating organisations, but I would particularly like to thank members of the Project Advisory Group, the National Heart Foundation of Australia (Victorian Division), the Victorian Health Promotion Foundation, and the office of the State Public Health Nutritionist for their responsiveness and willingness to assist in sharing their expertise and guiding this project.

In addition, I would also like to acknowledge the active support and enthusiasm of the many people working in the early childhood sector who were so willing to participate. In the hectic work of providing expert care for our children, and in managing and supporting services, you have somehow found the time to share your knowledge, your experiences, your wisdom and your frustrations. And this has been done always from the standpoint of wishing to improve the way in which children's services can be delivered in the best interests of Victoria's children and their families.

Meg Montague
Social Research, Policy and Evaluation Consultant
Project Consultant

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1. Background

In 2001, the Victorian Department of Human Services established the Eat Well Victoria Partnership (EWVP) with a membership of key public health nutrition stakeholders from government and non-government organisations and professional and academic institutions. The role of the Partnership is to provide advice to the Director of Public Health and to contribute "to the improvement in the capacity and infrastructure for effective public health nutrition interventions across Victoria" (See Appendix I).

The EWVP began its work with the adoption of an action plan that stated, as a first priority, that the Partnership would advocate for and support the development and adoption of public health nutrition policy in organised settings for children 0-12. To support this priority the Victorian Health Promotion Foundation provided funds to undertake a *Public Health Nutrition Policy Analysis Project*. The first phase of this project documented the reasons for a focus on children's nutrition, assessed what is known about nutrition interventions, and provided an overview of organised children's settings as potential sites for policy development and adoption (Montague 2002). In October 2002, the EWVP nominated long day care and family day care as the focus of the second phase of the project, and agreed that physical activity as well as healthy eating should be included in the light of the conclusions of the Victorian Obesity Summit.

1.1 Process

This document has been developed over the first half of 2003 with input from a wide range of stakeholders (Appendix II), and from the Project Advisory Group (Appendix III). In addition, key stakeholder organisations and individuals were asked to comment on a draft before the Eat Well Victoria Partnership endorsed the finished paper (Appendix IV).

The paper has been written from an understanding of several key propositions regarding long day care and family day care and the early childhood sector of which they are a part. Firstly, the early years of zero to five years are critically important. It is in these early years that key development occurs and patterns of behaviour are laid down that will influence lifelong health and development (DHS 2001, Commonwealth of Australia 2003). As a society, our future lies in our children, and investment in early childhood is an investment in our own future. The early childhood sector is increasingly seen as providing important settings where early intervention can occur. This can involve the modelling of healthy behaviour and the provision of information about healthy behaviour to children and families, as well as the linkage of families to appropriate community organisations and specialised services.

Secondly, expectations of early childhood services as sites for early intervention have increased markedly over the last decade. We have reached a point where the capacity of early childhood services to meet these expectations is stretched to the limit and an increase in resources to the sector is required to match the increase in expectations.

The paper has been written from an understanding that to investigate the capacity of family day care and long day care to model healthy eating behaviour and physical activity patterns, we must consider the opportunities and the barriers within the early childhood sector and the broader community environment, not just within the settings. Health promotion evidence indicates that multi-faceted and multi-level approaches are required to achieve significant public health gains. Recommending actions to increase the capacity of family day care and long day care to model, inform and link, must of necessity involve recommending actions at the sector level and within the broader environment that involve attitude, behavioural, structural and environmental change.

1.2 Structure of the paper

The paper consists of five sections.

1) This brief introductory section.

2) An overview of the history, nature and scope of long day care (LDC) and family day care (FDC).

Followed by sections 3, 4 and 5 each of which take a multilevel perspective covering environmental, sectoral and setting based issues.

3) A discussion of the opportunities that currently exist to promote and enhance the adoption of healthy eating and physical activity policy and practices in both FDC and LDC.

4) A discussion of the barriers that currently inhibit the adoption of healthy eating and physical activity policy and practices in both FDC and LDC.

5) A strategic action framework for enhancing the adoption and implementation of healthy eating and physical activity policy and practices in both FDC and LDC settings.

2. Introducing family day care and long day care

In 1999, the number of children in Victoria who attend family day care (FDC) or long day care (LDC) on a part-time or full-time basis was recorded as 64,800: 20,400 or 31.5% in FDC, and 44,400 or 68.5% in LDC (ABS 2000). On 1999 figures, almost one in five or 17.5% of all Victorian 0-5 year olds attended centre or family based care for some or all of the week.

There are currently 73 FDC programs in Victoria; the majority (77%) are run by local government authorities, the rest operate under the auspices of not-for-profit agencies in the health and welfare sectors. LDC operates from a wider variety of bases, classified as

- *Community-based:* non-profit services incorporating parents on their management committees,
- *Private-for-profit:* owned and operated by individuals or companies and run on a for-profit basis, and
- *Other centres:* non-profit centres such as those provided by employers for their employees and centres at TAFE colleges.

It is difficult to be certain of the actual number of LDC centres at any one time. In 1999, the Australian Bureau of Statistics childcare census data (ABS 2000) recorded a total of 816 Victorian centres of which 33% were community-based centres, 57% were private-for-profit and 10% were other centres. However, by 2003, the Department of Human Services estimates that there are 835 licensed LDC centres in Victoria.

Over the last ten years or so there has been a significant growth in the number of childcare places, but most of the growth has occurred in the LDC sector. Between 1991 and 1999, the number of LDC places increased by over 150% and FDC places by 51%. The growth in the number of children using services was somewhat lower than the growth in places, an increase of 122% of children using centre-based care, and 38% of children using FDC. Although the increase in paid workers in LDCs (125%) has been commensurate with the growth in children's numbers, FDC co-ordination unit staff increased by only 14% and the number of FDC carers fell by 9% over the period. Overall, FDC seems to be shrinking (see discussion in section 2.3).

LDC centres have tended to increase in size over the period, and the growth has been most marked in the private-for-profit sector. In 1999, 21% of community-based centres were large (over 60 places), compared to 44% of private-for-profit centres and 30% of other centres.

The federal government currently supports the provision of LDC and FDC services through means tested fee relief for parents using the services (Child Care Benefit). FDC co-ordination units and a few LDC services in rural, remote and urban fringe areas also receive some operational funding. The federal government used to provide operational subsidies to all community-based LDC centres but this ceased in 1997. The impact of this is still not entirely clear, but anecdotally it has placed significant financial pressure on LDC, particularly in the community-based sector.

A review is currently being conducted of federal funding for children's services generally, under the *Child Care Support Broadband Redevelopment*. This review may significantly alter the funding arrangements for FDC, LDC, rural mobile child care services, occasional care, and out of school hours care, as well as the provision of funds to the specialist organisations that resource the early childhood sector such as Community Child Care, the Lady Gowrie Training and Resource Centre, the FKA Multicultural Resource Centre, the Victorian Society for Children's Co-operative for Ethnic Groups (VICSEG), Playworks Resource Centre for Children with Disabilities, the Victorian Aboriginal Education Association and the Family Day Care Resource Unit. Decisions from the Broadband Redevelopment process are anticipated in July with implementation over the 2003-04 financial year.

2.1 Family day care

FDC was established in Victoria in 1972 and provides care for children in a home environment. Each carer may care for up to four children under five years of age who are not attending school, and up to seven children in total. FDC provides flexible hours of care, including long day, part-time or casual care, before and after school hours care, holiday care, overnight and weekend care. Carers may also drop off and pick up children from school or kindergarten. FDC has significant flexibility. Carers can provide short-term care for the children of seasonal or sessional workers, or deliver emergency or respite care for children of families in crisis. On the other hand, a carer may provide care for children from the same family from birth, right through the preschool years and up to 12 years of age when they finish primary school.

Carers receive between $3.50 and $4.00 per child per hour, however many parents actually pay considerably less than this as they receive the Child Care Benefit based on their income. Rebates can be paid on up to 50 hours a week of work, study or training related care, amounts depend on income and number of children. A 50-hour weekly fee ranges between $150 and $180 for the core hours between 8am and 6pm. Higher fees apply for non-core hours. A family receiving the maximum rate of Child Care Benefit ($133) may pay between $17 and $47 a week.

The 73 FDC programs in Victoria, with approximately 3284 carers provide care for over twenty thousand children. Programs vary considerably in size from the largest with 240 carers, the smallest only ten. The 1999 ABS census reports that 15% of FDC programs have 40 or fewer equivalent full time places, while 76% have more than 200. The majority of programs are in non-metropolitan areas (41 or 56%) and the majority are managed by local government (56 or 77%).

Table 1: Program Location and Program Management

Location of Program	**Management of Program**		**Total**
	Local government managed N (% of LGA programs)	**Non-government organisation managed** N (% of NGO programs *****)	N (% of all FDC programs)
Metropolitan	28 (50%)	4 (24.5%)	32 (45%)
Non-Metropolitan	28 (50%)	13 (76.5%)	41 (56%)
Total Number **% of all FDC programs**	56 (77%)	17 (23%)	73 (100%)

Source: data provided by FDCV March 2003

*Non-government organisations include:

Metropolitan-based programs

- Sunbury Community Health Centre (1)
- Southern Health Care Network (1)
- Brotherhood of St Laurence (1)
- Local community based committee of management in Dandenong (1)

Non-metropolitan-based programs

- Kilmany Family Care (5)
- Upper Murray Community Care (2)
- Euroa Bush Hospital (1)
- Eaglehawk Community Health Centre (1)
- Kyneton Community Health Centre (1)
- Uniting Church (1)
- Local community based committee of management in Alexander (1) and Daylesford (1)

The FDC sector appears to have been shrinking. The number of carers has declined by 9% between 1991 and 1999, with a steeper decline (17%) evident between 1997 and 1999 – from 3966 carers in 1997 to 3284 in 1999. Similarly, while the number of children in FDC increased by 38% between 1991 and 1999, it has actually declined by 11% over the 1997-1999 period, from 23,250 in 1997 to 20,717 in 1999 (DHS 2001:32). Rather than the result of a lack of demand for FDC, this appears to be due to difficulties in recruiting and retaining carers. This is not however, the case in all areas, for example the City of Casey which has a rapidly growing population of young families and a very large FDC program with 240 carers, maintains a waiting list of people wishing to become carers.

FDC co-ordination units receive an operational subsidy from the federal government. Up until January 2001 the subsidy was only available to community based, not-for-profit organisations. Since that time, other operators, including private for-profit organisations and operators of community-based children's centres, have became eligible to supply FDC places in areas of identified need. As yet no private operators have entered the field in Victoria. The federal government also provides funds for a state based peak body and for a FDC Resource Unit that provides information, advice and support to all Victorian FDC programs.

To date Victorian FDC has been relatively unregulated (DHS 2001), particularly in comparison to the LDC sector. National standards for carers (1995) and for co-ordination units (1998) were agreed to by state, territory and federal ministers, and incorporated into a formal framework in 1999. However, Victoria has not yet translated this agreement into legislation. While the Victorian peak body for FDC, Family Day Care Victoria (FDCV), has adopted these standards they are advisory only, there is no external agency or body for monitoring and enforcing these standards in Victoria. In 2001, DHS published a discussion paper around the proposed amendments to the Children's Services Act (1996) that were to introduce regulatory standards for FDC and Out of School Hours Care using the national standards as a framework. Progress seems to have stalled in this area, and may not now proceed until after 2003, the first year of FDC accreditation (see below).

In 2001, the federal government launched a national quality assurance system for FDC (following the earlier development in LDC). This system and associated accreditation are linked to on-going funding as is parents' access to Child Care Benefit. After a lengthy consultation and development phase, the first year of accreditation in FDC is underway in 2003.

The quality assurance system includes *Quality Element 4: Health Hygiene, Nutrition, Safety and Wellbeing: Principle 4.2* that requires that the FDC program have "a written nutrition policy that is based on current advice from relevant health authorities, is culturally sensitive and is reflected clearly in the practices of carers." There is no requirement to have a policy in relation to physical activity, however, *Quality Element 3: Children's Experiences, Learning and Development: Principle 3.5* requires carers to "support the physical development of children".

2.2 Long day care

LDC centres have been operating for much longer than family based care. Centres range in size from as low as twenty places up to one hundred plus, though smaller centres have been encouraged to expand, amalgamate or close in recent times. LDC centres are staffed by a mix of trained childcare staff and unqualified assistants. Care is provided for children between 0 and 5 for up to 60 hours a week or 12 hours a day, and over 48+ weeks a year. Weekend or overnight care is rarely available. Fees can be quite substantial and can be over $250 per week for full time 50 hours of care. Again parents may not pay this full amount, however the maximum Child Care Benefit of $133 represents a lower proportion of the full fee compared to FDC.

Management arrangements in the LDC sector are more diverse than FDC with a strong private-for-profit as well as not-for-profit sector that includes local government, community welfare and religious organisations, as well as employer sponsored, or university or TAFE college managed centres, and even parent managed co-operative centres. In recent years corporate childcare has emerged, where private operators have floated corporations on the stock market that own or manage centres.

A number of representative bodies operate in relation to LDC centres; Community Child Care in the community managed sector, Child Care Centres Association of Victoria representing for-profit private centres though it does provide some membership services in relation to industrial and training issues for non-private centres and individuals wanting to enter the industry, and the peak body in the for-profit sector, the Victorian Private Child Care Association.

Since the mid-1990s, the National Childcare Accreditation Council (NCAC) has accredited LDCs based on the meeting of quality standards. Payment of federally funded Child Care Benefit to parents is dependent on centres meeting these quality standards. Sections directly relevant to nutrition cover the social context of eating, the development of healthy eating habits, food safety and food handling, nutrition policy and the provision of nutritious and culturally relevant food.

Quality Area 2: Respect for children: Principle 2.4: "Mealtimes are pleasant, culturally appropriate occasions and provide an environment for social learning and positive interaction"

Quality Area 7: Protective care: Principle 7.1: "The centre has written policies and procedures on child protection, health and safety, and staff monitor and act to protect the health, safety and well-being of each child." Nutrition and food handling and storage are two of eleven areas suggested for inclusion in the written policies.

Quality Area 8: Health: Principle 8.1: "Food and drink are nutritious and culturally appropriate and healthy eating habits are promoted." Detailed indicators of "satisfactory care" and "high quality care" provide guidance on:

- Maintaining current information on nutrition
- Developing and implementing nutrition policy
- Inclusion of current recommendations on nutrition
- Food supply reflecting Commonwealth and State recommendations on children's food requirements
- Flexible arrangements for age, individual preference and special needs dietary requirements and encouragement of healthy food habits
- Forward menu planning involving parents and evaluation of menus against nutrition guidelines
- Involvement of parents in nutrition education, policy development and implementation
- Nutrition training of staff.

The sections relevant to physical activity falls in *Quality Area 6, Principle 6.2*

- Physical development facilitates learning and progress in all other areas by allowing children to explore and master their environment. Physical development in early childhood occurs rapidly and a centre's program should give each child opportunities to gain balance, flexibility, strength, eye-hand co-ordination, fine and gross motor skills and other essential aspects of physical development.

At the state level, the Department of Human Services licenses LDCs on the basis of meeting minimum standards set by the Children's Services Act (1996) and the Children's Services Regulations (1998). Standards cover space, range of equipment, number and ages of children, number of staff and staff qualifications. The regulations require that

1) "The proprietor must ensure that facilities to cook or heat food, washing up facilities and refrigerated food storage facilities are available to and accessible by staff to enable them to prepare and provide food for children being cared for or educated by the children's service.
2) The proprietor must ensure that if food is supplied by the children's service and provided to the children at the children's service-
   a. a weekly menu is displayed describing the food to be provided each day;
   b. the food is adequate, both in quality and quantity, and appropriate to the children's growth, cultural and development needs.
3) The proprietor must ensure that if the food is provided to children at the children's service, whether or not the food is supplied by the service-
   a. the food is offered to children at frequent and regular intervals;
   b. cleanliness is observed where the food is stored, handled and prepared on the premises;
   c. all food consumed on the premises intended for consumption is protected at all times from contamination;
   d. there are suitable eating arrangements for children at the service.
4) In this regulation, "food" includes beverage."

The Act and the Regulations are accompanied by the Children's Services Licensing Operational Guide (1998). This Guide suggests (but does not require) the provision of healthy food and the development of nutrition policy. Section 4.3 Food and Hygiene reads:

"Quality and Quantity Suggested practice

Food must be appropriate to the children's growth, cultural development and needs. The food provided by the children's service should provide a varied, balanced diet in line with *National Health and Medical Research Council's Dietary Guidelines for Children and Adolescents*.

Developing a nutrition policy

The development of a nutrition policy is a practical way to promote good nutrition in your service. A nutrition policy will provide guidance to staff in the day-to-day operation of the centre. For further information about *Australian Dietary Guidelines* and meeting the nutritional needs of children contact the *Australian Nutrition Foundation*."

Neither the Act, the Regulations nor the Operational Guide contain explicit sections around physical activity. Section 3.1.1 of the Guide suggests ways in which services can meet the regulation to "ensure the safety of the children being cared for or educated and that their developmental needs are met". These suggestions address physical development, the provision of spaces where children can be "active and noisy", the provision of furniture and equipment appropriate to the developmental stages of the children. A range of equipment is suggested that can assist in the development of fine and gross motor skills.

In addition, LDC centres are required to meet the Victorian Food Act (1984), mandatory food safety regulations that are administered through local government on behalf of the state government. FDC programs are not covered by this legislation.

2.3 A statistical snapshot of family day care and long day care

The Australian Bureau of Statistics periodic Child Care Survey provides a range of data on the nature and scope of care in the two settings. Data on usage patterns and family characteristics are also available but should be used with caution, as many are estimated figures with high standard errors.

2.3.1 Usage patterns

However, with this caveat, the majority of children are in FDC and LDC less than full time (87% in FDC, 80% LDC <34 hours per week). However there are a proportion of children who spend over 40 hours a week in the care setting (6% in FDC, 12% in LDC >40 hours). Most children are in care three or fewer days per week.

Table 2: Weekly Hours of Care

Type of Care	Less than 5 N (% of type of care)	5-9 hours N (% of type of care)	10-19 hours N (% of type of care)	20-29 hours N (% of type of care)	30-34 hours N (% of type of care)	35-39 hours N (% of type of care)	40-44 hours N (% of type of care)	45 or more N (% of type of care)	Total
Family Day Care	4,200* (21%)	5,900 (29%)	6,100 (30%)	1,500* (7%)	**	np**	1,200* (6%)	np**	20,400
Long Day Care	1,600* (4%)	12,600 (28%)	12,200 (27%)	7,600 (17%)	1,800* (4%)	3,200* (7%)	1,800* (4%)	3,700* (8%)	44,400

Source: ABS Child Care Victoria June 1999

np not available for publication but included in totals where applicable, unless otherwise indicated.

* estimate has a standard error of between 25% and 50% and should be used with caution.

** estimate has a standard error greater than 50% and is considered too unreliable for general use.

Table 3: Number of Weekdays Care Used

Type of Care	Weekends only N (% of type of care)	One N (% of type of care)	Two N (% of type of care)	Three N (% of type of care)	Four N (% of type of care)	Five N (% of type of care)	Total
Family Day Care	**	5,900 (29%)	6,000 (29%)	2,100* (10%)	4,200* (21%)	2,200 (11%*)	20,400
Long Day Care	np**	13,800 (31%)	10,200 (30%)	6,900 (15.5%)	*np	9,400 (21%)	44,400

Source: ABS Child Care Victoria June 1999

The cost of care to families in 1999 was clearly higher in LDC than in FDC with three quarters of FDC users paying less than $40 a week, and two thirds of LDC using families paying more than $40 per week.

Table 4: Cost of Care per Week

Type of Care	No Cost N (% of type of care)	$1-$9 N (% of type of care)	$10-$19 N (% of type of care)	$20-$39 N (% of type of care)	$40-$59 N (% of type of care)	$60-$79 N (% of type of care)	$80-$99 N (% of type of care)	$100 or more N (% of type of care)	Total
Family Day Care	np**	3,500* (17%)	6,400 (31%)	5,700 (28%)	1,200 (6%**)	np**	1,100** (5.5%)	1,000** (5%)	20,400
Long Day Care	np**	1,400* (3%)	00 (13.5%)	6,900 (15.5%)	9,300 (21%)	5,000 (11%)	4,500 (10%)	10,800 (24%)	44,400

Source: ABS Child Care Victoria June 1999

2.3.2 Family characteristics

Children attending FDC come from a wider age range than children attending LDC, and tend to be older. This reflects the capacity of FDC to provide out of school hours and weekend care.

Table 5: Age of Children in FDC and LDC

Type of Care	Under 1 N (% of type of care)	1 N (% of type of care)	2 N (% of type of care)	3 N (% of type of care)e	4 N (% of type of care)	5 N (% of type of care)	6-8 N (% of type of care)	9-11 N (% of type of care)	Total
Family Day Care	np**	2,200* (11%)	3,400* (17%)	5,500 (27%)	3100* (15%)	2,900* (14%)	2000* (10%)	np**	20,400
Long Day Care	2,000* (4.5%)	9,700 (22%)	11,500 (26%)	9,800 (22%)	7,700 (17%)	3,700* (8%)	**	**	44,400

Source: ABS Child Care Victoria June 1999

Tables 6 and 7 indicate that a greater proportion of FDC using families compared to LDC using families are one parent, low income, non-metropolitan based families that speak a language other than English at home.

Table 6: Family Type, Main Language Spoken at Home and Area of Usual Residence of FDC and LDC Using Families

Type of Care	Family Type		Main Language Spoken at Home		Area of Usual Residence	
	Couple family N (% of type of care)	**One parent family** N (% of type of care)	**English** N (% of type of care)	**Other language** N (% of type of care)	**Melbourne** N (% of type of care)	**Balance of Victoria** N (% of type of care)
Family Day Care	15,000 (74%)	5,400 (26%)	18,200 (89%)	2,200* (11%)	10,300 (50.5%)	10,200 (50%)
Long Day Care	37,900 (85%)	6,500 (15%)	40,800 (92%)	3,600* (8%)	35,000 (79%)	9,100 (21%)

Source: ABS Child Care Victoria June 1999

Table 7: Weekly Family Income of FDC and LDC Using Families

Type of Care	Less than $400 N (% of type of care)	$400-$599 N (% of type of care)	$600-$799 N (% of type of care)	$800-$999 N (% of type of care)	$1000-$1199 N (% of type of care)	$1200-$1399 N (% of type of care)	$1400-$1999 N (% of type of care)	$2000 or more N (% of type of care)	Don't know or not stated N (% of type of care)	Total
Family Day Care	4,100* (20%)	4,600* (23%)	2,500* (12%)	1,600* (8%)	1,900* (9%)	np	1,600* (8%)	np	2,700* (13%)	20,400
Long Day Care	4,200* (9.5%)	4,300 (10%)	5,100 (11.5%)	7,700 (17%)	4,800 (11%)	3,500* (8%)	8,500 (19%)	1,100** (2.5%)	5,100 (11.5%)	44,400

Source: ABS Child Care Victoria June 1999

Despite these socio-demographic differences, FDC and LDC families appear to have similar labour market profile, with the majority having one or more parent in employed full or part time work (Table 8).

Table 8: Labour Force Status of FDC Parents

Type of Care	Both parents employed working FT[(a)] N (% of type of care)	Both parents employed at least one working PT[(a)] N (% of type of care)	One parent employed, other not in the labour force N (% of type of care)	One parent unemployed other not in labour force N (% of type of care)	Both parents in labour force, at least one unemployed[(a)] N (% of type of care)	Both parents not in the labour force N (% of type of care)	Total
Family Day Care	5,300 (26%)	8,400* (41%)	2,100* (10%)	np**	2,500* (12%)	np*	20,400
Long Day Care	11,700 (26%)	19,500 (44%)	7,100 (16%)	np**	np*	3,100* (7%)	44,400

Source: ABS Child Care Victoria June 1999
(a) Includes one parent families

2.3.3 Staffing

In 1999, the 73 FDC program co-ordination units employed 315 staff. The majority (97%) of the units employed fewer than 10 workers, with an average of five workers per program overall (AIHW 2002:47). Over 3000 carers were involved with a third of programs having more than forty carers, and another third more than 60 (Table 9).

In 1999, there were 8723 workers in LDC centres, the majority (4,631) in private for profit centres, 3210 in community based and only 882 in other centres. This represents an average of between 11 (other centres) and 13 (community centres) staff per centre. Private centres tend to be smaller, over half have under 10 staff, while almost one half of community based and other centres have between 10 and 14 staff.

Table 9: Number of staff per FDC program and LDC centre

Setting	Number of staff %					
	<5	**5-9**	**10+**			
FDC Co-ordination Unit staff	51%	46%	3%			
	<20	**20-39**	**40-59**	**60+**		
FDC carers	14%	23%	25%	38%		
	<5	**5-9**	**10-14**	**15-19**	**20+**	**Average staff per centre**
LDC Community based centres	0	23%	47%	23%	6%	13
LDC Private for profit centres	3%	49%	16%	23%	9%	12
LDC other type centres	3%	30%	49%	14%	4%	11

Source: AIHW 2002

The 3284 carers in FDC are generally self-employed contractors responsible for their own insurance and taxation. In only three Victorian FDC services are the carers employees of the service. The 1999 census identified that 74% of carers had no qualifications in teaching, nursing or early childhood or other relevant areas, (for example a certificate in home based care, a nanny's course, social work, other teaching or business management). Of these 2430 unqualified carers, 3% were undertaking a qualification, 42% had worked in the industry for more than three years and 30% were neither experienced nor in training.

The 315 staff working in FDC co-ordination units were also relatively untrained, with 28% having no qualifications at all, despite nationally agreed standards specifying that minimum qualifications for a FDC co-ordinator is "a diploma of 2 years full-time study in early childhood studies or behavioural sciences conducted by a registered training organisation." Nearly one fifth or 19% were described as having no qualification but having worked in the industry for more than three years. Over half FDC co-ordination staff (54%) worked on a part-time basis, 43% on a full time basis and 3% were casual staff.

The LDC workforce has higher proportions of qualified workers. Overall, 60% are qualified and 40% are unqualified. Proportions vary across centre type: in community based centres 65% are qualified, private-for-profit centres 56% are qualified, and 'other' centres where 64% are qualified. Of the unqualified workers in LDC some 11% (community based centres) and 20% (private-for-profit centres) were neither in training nor had been in the industry for more than three years.

2.3.4 Summary

This section has given a snapshot only of the two day care settings, the reader is referred to the Australian Institute of Health and Welfare document if greater detail is required (AIHW 2002).

3. Opportunities for the enhancement of healthy eating and physical activity policy and practice

Opportunities for encouraging and enhancing the adoption and implementation of healthy eating and physical activity policy in FDC and LDC lie in three main areas; the community environment within which FDC and LDC operate; the early childhood (EC) sector generally, and the specific FDC and LDC settings. Table 10 summarises the opportunities and the text below discusses them in more detail.

Table 10: Summary of opportunities influencing the development of healthy eating and physical activity policy development in FDC and LDC

Community Environment	Early Childhood Sector	FDC/LDC Settings
1) Current government policy and program emphasis on early years intervention. 2) Growing government commitment to healthy eating and physical activity as components of obesity prevention. 3) Rising community awareness of the importance of healthy eating and physical activity especially in childhood. 4) Increasing body of knowledge about effective healthy eating and physical activity interventions.	1) The federal accreditation and state regulatory frameworks for early childhood services. 2) The nature of early childhood services as an important interface between families and early childhood staff that involves modelling appropriate behaviour, information provision and linkage to other services. 3) The commitment of early childhood services staff to children's wellbeing. 4) The recent development of healthy eating and physical activity resources specifically geared towards early childhood settings.	**1) The nature of FDC:** • Ease of reaching a relatively small and coherent setting. • Role of local government & welfare organisations as management agencies. • Nature of the relationship between carers & families. • Provides opportunities to reach low income, culturally & linguistically diverse communities and recent arrivals in Australia. **2) The nature of LDC:** • Potential impact of market forces in LDC. • High levels (60%) of EC qualified staff. • Long periods spent in LDC by many children: 20% spend over 35 hours per week. • Nature of the relationship between LDC workers & families.

3.1 Environmental opportunities

3.1.1 Current government emphasis on early years intervention

There is growing government emphasis on the importance of the early years in children's lives as the seeding ground for lifelong health, resilience, growth and development. Examples of some current policy and program initiatives include the federal government's National Agenda for Early Childhood and the Stronger Families initiative; and at the state level the Strengthening Families Initiative, the Best Start Prevention and Early Intervention Project, the government's commitment to Neighbourhood Renewal, the current review of Maternal and Child Health and the requirement that all municipalities will develop an early childhood strategy.

The Victorian Labor government also made a pre-election promise to establish a Children's Advisory Committee to advise the Premier on the development of an integrated whole of government Victorian Children's Services Strategy. These initiatives provide significant opportunities to emphasise the importance of healthy eating and physical activity and for these two elements to be more prominent as aspects of these early years initiatives.

3.1.2 Growing government commitment to obesity prevention

Governments are becoming increasingly aware of the importance of healthy eating and physical activity in the face of mounting evidence of an epidemic of obesity and overweight among younger and adult Australians.

The federal government has been involved in the development of a number of strategic agendas under the National Public Health Partnerships umbrella including:

- the Strategic Intergovernmental Nutrition Alliance (SIGNAL)
- the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP)
- the Strategic Intergovernmental Forum on Physical Activity and Health (SIGPAH) and
- the one-off time-limited commitment to 100 National Child Nutrition Projects 2000-2003.

The Victorian government too has become increasingly committed to obesity prevention. The *Active for Life Strategy* (Active 1999) aims to increase and enhance lifelong participation in physical activity, and the Victorian Obesity Summit in October 2002 prompted a major focus on obesity and diabetes prevention (ALP 2002) in the election to be followed through during the current term of office.

3.1.3 Rising community awareness

Victorians are becoming more aware of the importance of healthy eating and physical activity particularly in children. However, this awareness is by no means consistent nor universal and it is debateable how much is actually translated into behaviour change. Many admit to confusion about how best to respond to their raised awareness in the face of seemingly conflicting advice.

Parents themselves, as well as early childhood, parenting and health professionals, are increasingly commenting on nutrition and physical inactivity related issues that they are encountering, including:

- behaviour problems associated with food or meal times, such as fussy eating or food refusal,
- rising rates of food related dental caries in young children,
- increasing trends in early onset of Type 2 diabetes in children,
- iron and/or Vitamin D deficiency,
- higher rates of overweight and obesity in children,
- increasing number of hours spent by young children in sedentary activities such as television and video watching, computer games etc
- concerns about rising consumption of foods that are high in energy and low in nutrients.

Opportunities clearly exist to build on this awareness and to provide a framework for delivering information, advice, and support on nutrition and physical activity related issues.

3.1.4 Increasing knowledge about effective interventions

There is an increasing body of knowledge about effective nutrition and physical activity interventions. We have a number of overviews of the research, including the Deakin University review of child nutrition and obesity interventions (Worsley et al 2002), the World Health Organisation report on *Diet, nutrition and the prevention of chronic diseases* (World Health Organisation 2003), and the work of Bauman et al 2002 around physical activity. In addition, several projects have been evaluated and show encouraging results: the evaluation of the Western Australian Start Right Eat Right initiative (Pollard et al 2001), the evidence from the evaluations of the National Child Nutrition Projects, and in Victoria, the Filling the Gap project, the local pilot of Start Right Eat Right, and a number of Primary Care Partnership projects with a nutrition focus such as the South West Early Childhood Nutrition Project "Food to Grow On".

3.2 Opportunities in the early childhood sector

3.2.1 The accreditation and regulatory environment for early childhood services

A number of changes in the accreditation and regulatory environment have occurred, are in train or are under consideration. These changes may provide opportunities to encourage or drive the adoption of healthy eating and physical activity policy in early childhood services. It should be noted however, that some of these changes have actually or potentially the capacity to hinder changes in policy and practices (see section 4).

Firstly, the national quality improvement and accreditation system, by identifying standards and indicators of good practice has acted as a spur to action around healthy eating and physical activity. LDC centres have been subject to this system since the mid 1990s, while FDC is engaging in its first year of accreditation in 2003. However, the sector complains that there is a lack of specificity about what high quality care indicators in nutrition actually mean, and there is a lack of clear direction around physical activity. The lack of congruence between the national accreditation system and the state licensing requirements tend to confuse early childhood workers, and has hindered interpretation and implementation.

Secondly, opportunities lie in the current Victorian children's services standards and licensing system as well as its future development to include FDC. Discussions around the inclusion of FDC in the licensing and monitoring framework have stalled in the last year or so. However, the potential remains for a reconsideration of the Children's Services Act in such a way that the national accreditation system and the state licensing system are brought into closer relationship.

Thirdly, the federal government's Child Care Support Broadband Redevelopment process may have an impact on funding for children's services and for training and support organisations for early childhood services. While the outcome is not yet certain the review itself provides an opportunity to raise the profile of healthy eating and physical activity policy and practices in children's services.

Finally, the implementation of the Victorian Food Act in LDC settings (but not FDC) has fuelled greater attention to food handling issues and raised food issues in children's services generally. Whilst some identify this as an opportunity in that LDC centres have had to put considerable energy and resources into compliance, more believe the legislation and its implementation have in fact acted as a barrier to the commitment of time, energy and resources to healthy eating policy and program development.

3.2.2 The interface role of early childhood services

Early childhood services play a unique role in providing a setting for extended and continuous contact between carers, children and parents. This provides an excellent opportunity to introduce children as well as parents to good food and physical activity habits by modelling appropriate behaviour, by providing information on food and activity to parents and by providing links to community organisations. To maximise this opportunity, early childhood services need to operate with a commitment to family centred practice.

3.2.3 The commitment of early childhood workers to children's wellbeing

Early childhood services workers, both those with and without formal qualifications, generally have a strong commitment to children's wellbeing and healthy development and are keen to learn about and adopt practices that will assist them to do their job well. However, the opportunities this orientation presents needs to be viewed in the context of the high expectations placed on staff in these services and the frustration felt by many that the critical importance of their role is not understood or valued. A tendency to be child rather than family centred can also limit the impact of this commitment.

In relation to FDC, there appears to be a general sense that this sector has been a relatively ignored or neglected part of children's services. FDC program co-ordinators and carers respond positively to initiatives that focus on FDC and are tailored specifically to the needs of the FDC sector.

3.2.4 The development of early childhood specific resources

In Victoria over the last few years, we have seen the development of a number of specifically tailored resources to support interventions in early childhood settings, including:

- *What's There to Eat? The practical guide to feeding families,* a resource manual for early childhood service providers about food and nutrition and how to encourage healthy eating in families,
- *Filling the Gap Nutrition Tip Sheets* on various topics including "Why no sweet drinks for children", "Food in the first year of life", developed by the Royal Children's Hospital (RCH) and the Department of Human Services (DHS) for parents and carers of young children,
- *the Start Right Eat Right nutrition award scheme,* a DHS funded project that is piloting a best practice nutrition award system in LDC,
- *Relaxed and Social: A positive approach to children's healthy eating,* a resource developed by RCH and the Centre for Community Child Health, that aims to assist parents and LDC staff to provide a relaxed eating environment for children and families and to increase communication between LDC carers and families around food and eating,
- *Easing the Transition* a resource for primary health care workers, developed by the Victorian Foundation for Survivors of Torture to assist new arrivals to access diet and lifestyle information while learning English as a second language,
- a range of *Nutrition Australia* resources that focus on meeting the nutritional needs of young children, nutrition policy development and implementation in early childhood settings, and
- the *Early Childhood Physical Activity Guidelines* launched this year by the National Association for Sport and Physical Education.

While these resources have some relevance to FDC settings, they were generally developed with a specific LDC focus. In the last year however, there have been two important resources specifically designed for FDC.

- *Good Food in Family Day Care: A food and nutrition information kit* was developed in New South Wales with support from the National Family Day Care Council of Australia. The resource has been distributed nationally to all FDC programs, but there are no funds to provide training or support to use the resource, and it does not appear to have reached individual carers, and rather has remained at the co-ordination unit level.
- *Active Care: A meaningful program for children in care* has recently won the 2002 Victorian Sport and Recreation Award. This consists of a training program for carers accompanied by a manual. The manual contains guidelines for physical activity for pre-school age children, suggestions of low cost equipment and activities for children. This resource is currently only available in the Latrobe Valley, but is being considered for national use.

An initiative that may provide training opportunities is the recent funding by the federal Department of Family and Community Services (for 2003 only) of the Child Care Services Training Consortium to deliver in-service training to federal funded children's services across Victoria. This is intended to complement the support already provided by the existing range of resource and advisory services, but is to be reviewed as part of the Child Care Support Broadband Redevelopment process. This training will be both cheap and flexible, it can be customised, provided out of hours and at weekends and therefore provides an important (but short term) opportunity to increase the training options open to early childhood services and FDC in particular.

3.3 Opportunities in family day care and long day care settings

3.3.1 Family day care

The coherent nature of family day care

The relatively small and coherent nature of FDC provides opportunities in terms of ease of access and congruence of goals. The 73 Victorian FDC programs each send a representative to their local monthly regional meetings, and then each region sends a representative to monthly statewide meetings. The Family Day Care Victoria Resource Unit (staffed by one person) supports all FDC Programs.

The role of local government and welfare organisations in family day care

Local government dominates the FDC sector (77% of FDC programs), with non-government not-for-profit organisations playing a lesser role. There has been no penetration into the sector by private for profit organisations, although this may happen in the future.

The government and non-government organisations that provide the auspices for FDC tend to have a community welfare and/or health focus. They often have some health or early childhood related infrastructure, and the potential exists for healthy eating and physical activity to be reinforced and supported by work in other areas. For example, in local government, nutrition policy development in children's services can inform and be informed by aspects of the Municipal Health Plan, the Maternal and Child Health network, the work of the Children's Services Resource and Development Officers and the Preschool Field Officers.

Nature of the relationships between carers and families

FDC is a particularly broad and flexible form of childcare. It is the only children's service that caters for children aged 0-12, and has the capacity to provide care over 24 hours a day, 7 days a week.

The ‘home like’ environment of FDC makes for the development of close one-to-one relationships between carers and families. This capacity to facilitate long-term relationships between carers and parents has both positive and negative aspects in relation to encouraging healthy eating. “We have a key opportunity to feed children properly and to influence, support and inform their parents, but you can give guidance only, they are not your children. And it is sometimes very difficult when you are more like friends to suggest that a parent is not feeding their child well, and to criticise the way they use food to reward or punish their child.”

Opportunities to reach low income and CALD families

ABS data suggest that FDC has higher levels of parents from low socio-economic and from culturally and linguistically diverse backgrounds (Tables 6 and 7). Many FDC carers are also from these backgrounds. FDC therefore provides an important interface for reaching both carers and families to provide healthy food and healthy environments for children.

3.3.2 Long day care

Potential impact of market forces in long day care

LDC is a more diverse setting with centres being run by a wide range of community as well as commercial and for-profit organisations. Potentially, (though reported as being limited in practice) the diversity and spread of LDC could mean that in order to attract parents, centres will raise standards and market themselves on the basis of “best practice”. Theoretically a competitive environment could stimulate improvements in healthy eating and physical activity policy and practices so as to attract customers/parents. However, the place of “market forces” in child care remains debateable in the face of limited supply relative to demand, particularly in relation to under two year olds.

High levels of early childhood qualified staff in long day care

LDC centres have a significant proportion (60% overall) of qualified staff (section 2.3.3) who would have been exposed to theory and practice of healthy eating and physical activity in children’s development.

Long periods spent in LDC by many children

Children can spend up to 60 hours a week in LDC over four to five years (section 2.3.1). Nearly 20% of children in LDC spend over 35 hours a week in the centre. They consume a large amount of their daily food intake there and spend a considerable proportion of their waking hours at the centre. This suggests significant opportunities for introducing eating and activity information and practices.

Nature of the relationship between staff and families

LDC shares some of the aspects of FDC in terms of the special relationship that can develop between carers and families. The fact that children may spend long periods in LDC and/or a number of years can result in long term relationships between children, staff and families that may open up opportunities for information sharing around difficult issues such as obesity and overweight as well as family eating and physical activity patterns. In addition, the ‘professional” status of childcare staff can encourage parents to request and value their information and advice.

4. Barriers to the adoption of healthy eating and physical activity policy and practice

Factors that inhibit the capacity of FDC and LDC to adopt and implement healthy eating (HE) and physical activity (PA) policy and practices also lie in the environment, the early childhood (EC) sector and the settings themselves.

Table 11: Summary of barriers affecting the development of healthy eating and physical activity policy in FDC and LDC

Community Environment	Early Childhood Sector	FDC/LDC Settings
1) Insufficient support in the broader environment for healthy eating and physical activity in terms of awareness, attitudes, behaviour, organisational and structural change. 2) Limited continuity and sustainability of nutrition and physical activity initiatives, and a lack of joint efforts in relation to healthy eating & physical activity. 3) Lack of an accessible, credible & up-to-date source of information, advice and support. 4) Dominance of a risk management framework.	1) Sector overload: pressures from high community & government expectations in the face of inadequate resources, low status of 'childcare' & low levels of remuneration. 2) Skills & knowledge gaps & lack of time, resources, replacement care & information to fill these gaps. 3) Lack of specialist paediatric & EC nutrition information and support. 4) Lack of culturally & linguistically relevant resources, information & training. 5) Lack of linkage between EC sector & other service systems eg MCH, MHPs, local government etc. 6) Tendency for early childhood sector to have child centred rather than family centred approach. 7) Challenges in communicating with parents about eating & physical activity related issues & lack of resources to support this. 8) Difficulties in involving parents in policy development.	**1) The nature of FDC:** • Self-employed & dispersed workforce. • Cultural & linguistic diversity among carers & families. • Diversity in food service arrangements. • Physical space, equipment & risk constraints. • Low levels of physical activity policy development. • Deficits in & lack of congruence between the regulatory & accreditation frameworks. • Some resistance to "over regulation" & "professionalisation". • Low level of EC qualifications among carers (26%) & co-ordination staff (28%). • Low level of compulsory pre- & in-service training, especially in PA. • Limited capacity to access in-service training. • Lack of knowledge of & access to existing HE & PA resources & support organisations. **2) The nature of LDC:** • Diversity of LDC. • Lack of access to nutrition information, support & resources. • Low levels of physical activity policy development. • Impact of hygiene focus & food safety compliance. • Few trained cooks and a lack of training for cooks. • Competing resource & time priorities, limiting expenditure on food and on training.

4.1 Environmental barriers

4.1.1 Insufficient support in the broader community

On the whole, despite rising awareness of the importance of healthy eating and physical activity for health, population based research indicates that the Victorian community has less than optimum eating and physical activity habits. Evidence from the three National Nutrition Surveys conducted in 1983, 1985 and 1995, indicate that energy intake increased significantly for both adults and children and trends appear to reflect rising consumption of foods such as sweet drinks, snack foods, sugar and sugar based products, which are high in energy and on the whole, low in nutrients. The most recent survey also indicated that less than half the children surveyed met fruit intake recommendations and only one third met vegetable intake recommendations. Fruit and vegetable consumption has declined since 1985.

Trends in overweight and obesity and data on physical activity patterns are also discouraging. Currently nearly half the Australian community does not reach recommended levels of at least 30 minutes of moderate to intensive physical activity on most days of the week (Armstrong et al 2000; Bauman 2002) and activity levels are declining. Victoria has been identified as one of the states to have the largest decrease in sufficient physical activity for health.

Despite some increase in knowledge and awareness about the importance of diet in health, many members of the community have little or no awareness of the elements of healthy eating in children or if they do, they lack skills or capacity to put this awareness into practice. As a community there remain a wide variety of attitudes, knowledge and behaviour in relation to food variety and volume, the importance of the eating environment, and healthy eating practices generally in young children.

Many community attitudes and practices have a bearing on children's eating and physical activity patterns, for example:

- The use of food by parents (and some carers) as a reward or punishment for "good behaviour', as compensation for attending child care or as a means of assuaging parent's guilt for sending children to childcare. In essence what is being described is the provision of high kilojule/low nutrient foods as a substitute for good parenting practices.

- The pressure on children and families to purchase and consume foods that contribute little to a healthy diet, or to consume energy dense foods too frequently for optimum health. This pressure emanates from various sources: from television advertising; incentives attached to fast food purchases; the prominence of fast food outlets, and of sweets, snacks, convenience and fast foods in supermarkets; the poor quality of "children's menus" in many restaurants; and the typical profile of items sold in school canteens, milk bars, etc.

- The issues faced by families of migrants and particularly among recently arrived communities from non-Anglo backgrounds. These issues include low incomes; lack of transport; little familiarity with Western food habits such as meal times, fast foods, supermarket shopping; the ready availability of soft drinks and lollies; the absence of traditional or culturally appropriate foods that may have constituted a healthy diet in their country of origin; physical and emotional trauma resulting from pre-arrival experiences, and the perception that adopting "Australian" food habits is a reflection of affluence and acceptance.

- The pressures faced by many families can result in healthy eating being a low priority. Life pressures such as low incomes, long working hours, or single parenthood can result in a lack of time or energy for food preparation, in reliance on fast food products, in the provision of inadequate meals for children after a day at child care, the absence of harmonious family meal times and the dominance of television in many homes.

- Many families face significant "food insecurity" issues, and are unable to adopt healthy diets because low incomes and high fixed expenditure on items such as rent and utilities, make it impossible for them to purchase sufficient or appropriate food.
- Pressures on working families that limit time available for parents to shop for and prepare nutritious meals, to support children's participation in outside play or to take children to organised sport.
- Low incomes inhibiting parents' capacity to involve children in organised sport.
- Assumptions made that small children are "naturally fit" and that no extra effort needs to be made to encourage physical activity.
- Perceptions of a lack of public safety limiting parents' confidence in taking children to the park, allowing children to participate in outdoor play in public spaces, and inhibiting the use of bicycles or walking to school, etc.
- Unrealistic expectations or demands on carers that children 'stay clean' limiting children's capacity to play, or children finding it difficult to engage in active play because of unsuitable clothes or ill-fitting shoes. This may reflect a lack of resources to provide suitable active play clothes and shoes, cultural attitudes about the appearance of children, perceptions that children should be neat and tidy when outside the home, a lack of time and energy to plan for active play and the washing that may ensue, or a combination of these and other factors.

In addition, there are a number of organisational and structural aspects of the environment that have contributed to the decline in physical activity generally, including:

- Shifts towards less physically active occupations, increased car use for transportation, labour and time saving devices such as lifts, escalators, motor mowers, leaf blowers etc, increases in sedentary recreational and work based activities such as television and video watching, computer use.
- Changes in housing design and increased apartment living with loss of personal gardens and private outdoor space for children's active play.
- Urban design factors that affect the availability and nature of space for outdoor exercise.

4.1.2 Limited continuity in healthy eating and physical activity initiatives

Over the last twenty years, Victoria, like other states, has not had a sustained, co-ordinated and consistent public health approach to healthy eating and physical activity or put another way, to healthy living and obesity prevention. Approaches have tended to be short term and fragmented, based on a project model, lacking in consistent leadership, inadequately evaluated or documented, and focussed either on healthy eating or on physical activity rather than taking a joint approach. There has also been an overall lack of co-ordination between national, state, organisation and local level initiatives.

Concerns have been expressed about a lack of consistency, continuity, sustainability and liaison between projects that are part of recent initiatives such as the National Child Nutrition Projects, Primary Care Partnerships, Best Start initiatives etc. For example, one of the few statewide projects under the NCNPs is the Kindergarten Parents Victoria *Food Facts for Preschoolers Program*. This project works across childcare and preschool programs and aims "to increase the capacity of early childhood services to deliver consistent, relevant and current nutrition information to preschool children and their parents". However, it appears not to have worked closely with other similar initiatives such as the state funded Start Right Eat Right award program, thereby potentially overlapping or duplicating effort.

4.1.3 *Lack of an accessible, credible source of information and support*

There is a general absence of a readily identifiable and credible source of information about nutrition, and early childhood staff frequently mention the difficulty they have in knowing where to seek information and advice to support their nutrition endeavours. The Filling the Gap project recently documented the lack of knowledge among Victorian childcare staff and their reliance on informal or food industry sources for nutrition and healthy eating information (Gibbons et al 2000, Graham et al 2000). Stakeholders consulted for the current project in FDC, LDC and peak agencies could not readily identify where to turn for the sort of advice and information they say they need about nutrition. This includes information about available nutrition training and resources, and advice about food additives, menus, age specific nutritional needs, specialist nutritional needs of children with allergies or disabilities (though the Royal Children's Hospital was mentioned in this regard), how to tackle specific eating behaviour, when to be concerned and how to act on concerns about overweight and obesity, how to communicate with parents about eating and obesity issues, and to discuss related parenting issues. They also commented on the concerns about "trustworthiness" of information provided by the food industry.

4.1.4 *Dominance of a risk management framework*

The increasing dominance of a "risk culture" in Victoria is described as affecting healthy eating and physical activity initiatives in a number of ways. The state government's investment in food safety is seen by many as dominating discourse about eating, syphoning energy and resources into compliance with mandatory standards without sufficient evidence of the necessity for and efficacy of these prescribed approaches, and perhaps most worrying of all, limiting the capacity of early childhood services to focus on healthy eating strategies. The risk culture around food has infiltrated childcare training courses, with concerns being expressed about the focus on food handling dominating course time at the expense of time spent on nutrition and healthy eating in childhood.

Fears about liability and risk are also reported as having an impact in the physical activity area. The provision of active play equipment in public places is being reconsidered in some areas, early childhood workers are described as being anxious about allowing children to engage in vigorous active play, or taking children out of the caring environment to visit local parks or playgrounds.

4.2 Barriers in the early childhood sector

4.2.1 *Sector overload: expectations and resources in early childhood services*

As part of the growing recognition of their importance as an interface with families with modelling, information and community linkages, early childhood services are in danger of being overloaded with responsibilities and expectations that are described as out of proportion to the capacity of the sector to respond. On the one hand, services are increasingly expected to provide professional and skilled childhood education and early intervention services with parent education aspects and community linkage roles. On the other hand, the resources available to the sector and the pay and conditions for early childhood services staff do not reflect this important role. Rather the pay scales in LDC and the predominant industrial arrangements and remuneration in FDC reflect an unprofessional casual child minding service type.

4.2.2 *Skill and knowledge gaps in early childhood services*

Early childhood sector workers vary widely in their knowledge of the key issues in healthy eating in children and in their awareness of the resources that already exist (Graham et al 2000, Gibbons et al

2000). While expressing a desire to find out more, they also state that they do not know where to turn for assistance, often relying on word of mouth and food industry provided material. Filling the skills and knowledge gaps is problematic. Early childhood services have limited funds to purchase training, cannot spare the time to attend training, and have difficulties in backfilling positions when workers undertake training.

4.2.3 Lack of specific early childhood nutrition information and support

Early childhood services expressed frustration at being unable to access affordable support around children's nutrition. Over the last few years the specialist children's services dietitians that were employed in each DHS regional office have gradually decreased to workers in only three regional offices, and all of these state that their jobs have moved from a balance of community and clinical work to predominantly clinical work.

Dietitians in community health are under significant pressure as they work across all sectors of the community not simply early childhood, and few have early childhood specific training, and again an emphasis on clinical work limits their capacity to engage in community education and public health promotion.

The nutrition department at the Royal Children's Hospital is unable to respond to requests for assistance from early childhood services, again because of pressure on staff and a requirement to focus on clinical work. Early childhood staff describe practitioners in private practice as unaffordable, focussed on clinical work and mostly without specialised paediatric or early childhood training.

4.2.4 Lack of culturally and linguistically relevant resources and training

Culturally sensitive information, resources and training around eating and activity in children are not generally available, and resources in community languages either for early childhood workers or families are notable by their absence.

4.2.5 Lack of linkage between early childhood and other sectors

The early childhood sector is not adequately linked to other key sectors in health, welfare and local government. For example, while improvements have been made, links between the Maternal and Child Health system and early childhood services could be strengthened, there could be greater integration between local government managed children's services and other local government health and welfare initiatives such as the Municipal Health Plan. Relationships between Early Years sections of DHS and other key areas such as Food Safety and Healthy Living could be enhanced.

4.2.6 Child centred rather than family centred approach

The predominant approach in many parts of the early childhood sector is child rather than family centred. This leads to a lack of clarity at times about appropriate roles in relation to areas such as food. This becomes evident where early childhood staff express concerns that while they are happy to provide nutritious food to children in their care, they are not happy about "being expected to tell parents what to feed their children". Adopting a family centred approach to practice clearly identifies early childhood staff as playing an important role in modelling, information provision and service linkage for families around nutrition in the best interests of children's development.

4.2.7 Challenges in communicating with parents

One reflection of this lack of a family centred approach can be seen in the difficulties early childhood workers identified in communicating and being assertive with parents. They find it challenging to raise issues with parents such as what is appropriate food to bring to care, children's nutritional needs outside care, a child's overweight or obesity, family eating behaviour such as fast food consumption patterns and parenting strategies that use food as rewards, bribes, or punishment.

Workers also identified what they see as an absence of written material they can offer parents to assist in these nutrition related discussions and to encourage parents to implement healthy eating practices at home. Communicating with all parents was described as difficult, with parents from culturally and linguistically diverse backgrounds described as extremely challenging.

4.2.8 Difficulties in involving parents in policy development

In all early childhood services, be they centre or family based, it is difficult to engage parents in the process of policy development. Requests to attend meetings, focus groups, to provide written or verbal feedback usually elicit a low response rate even in areas such as menu planning. By definition, all the families using early childhood services have young children and many are in the labour market, seeking paid employment or are under some kind of pressure be it due to settlement, social or economic stress. All parents have limited time and multiple pressures and are difficult to involve in daytime or after hours activities. Parents from lower income and culturally diverse backgrounds are particularly challenging to engage in policy and program commentary.

It can also be difficult to involve early childhood workers for a number of reasons that include their focus on care provision rather than on policy or standards, their long hours, lack of interest in or understanding of the role of policy, and a range of social and cultural factors that may make attendance at out of hours sessions difficult.

4.3 Barriers in family day care and long day care settings

4.3.1 Family day care

In some senses, the very aspects of FDC that make it a flexible, cheap and attractive option to parents (and governments) can be seen as a barrier to the development of healthy eating and physical activity policies.

A self employed and dispersed workforce

Only three of the Victorian programs treat their carers as employees, all other programs contract them as self-employed operators. As such the carers are in the position of being responsible for their own insurance, taxation, work environment and the majority of their professional development, while having no control over the fees they can charge, the paperwork they have to complete and provide for the federal government, the number of children they can care for and the framework for the delivery of their service.

Carers are spread widely in the community, and particularly in rural areas there may be considerable distances involved in bringing carers together and in sending field officers to visit carers' homes. This has implications for the delivery of training, the development of policy and the monitoring of implementation.

Cultural and linguistic diversity among carers and families

ABS data indicate that almost one quarter of FDC carers in Victoria come from a culturally diverse or indigenous background and 11% of families speak a language other than English at home. Particularly in the metropolitan inner city, FDC programs have a large proportion of carers and families from culturally and linguistically diverse backgrounds. This represents a challenge to the development and implementation of healthy eating policy and practices. There are many aspects to this: differing cultural views and practices around child rearing and food, a lack of literacy skills in English and in home languages, lack of bilingual resources and workers particularly in communities recently arrived in Australia and a lack of healthy eating and physical activity resources that incorporate culturally diverse practices and are translated into community languages.

Diversity in food service arrangements

There is a wide variety of ways in which children's food is provided or supplied. This varies from program to program and from carer to carer. In some instances each child's food is provided by their parents. In others, the family provides some of the food, and the carer provides some, and in yet others the carer provides all the food. Some carers organise for families to share the purchase of staples (eg milk, bread, cereals, fruit), while the carer provides the rest. Policy and resource development need to acknowledge this diversity.

Physical space, equipment and risk constraints

The physical environments within which FDC is provided and a lack of appropriate equipment can act as a constraint on the capacity of carers to offer children a range of active play. In some carers' homes, particularly in the inner city suburbs where carers may live in high rise apartment accommodation, there is a lack of physical space and equipment such as tricycles for active play, and there may also be a lack of undercover or well-shaded outdoor space, and lack of local access to playgrounds.

A project focussing on fostering physical activity in FDC in the Latrobe Valley (O'Connor et al 2002) describes some carers as not being physically active people themselves and so not perceiving the need to take children to the park, or playgroups, or to encourage active play out of doors. Carers also described anxieties about allowing active play indoors and out because of the potential for accidents and therefore liability.

The nature of a setting where there is one carer with up to seven children can make it difficult to organise time out of doors, even if suitable space is available. In a situation where babies need to sleep during the day, a solo carer can find it difficult to schedule outings for older children.

In some FDC settings, there can also be a lack of appropriate equipment for the provision of an optimum eating environment for young children. Reports have been received of FDC carers with no high chair so the child had to be fed in the pusher, which means spoon feeding rather than self feeding; toddlers being perched on bar stools at a high bench; and no suitable chairs and tables for small children to sit at comfortably while having a meal or snack.

Low levels of physical activity policy development

While most FDC programs have a written nutrition policy, few if any have an explicit policy around physical activity. The national accreditation system does not require this.

Deficits in the regulatory and accreditation framework

Victoria has not yet formally adopted national standards for FDC. The national accreditation framework lacks specificity in relation to physical activity and even the nutrition area which does require a written policy, has been described by a state training body as "too loose and open to interpretation". Greater specificity and congruence between the state and federal frameworks could play a role in stimulating both physical activity and nutrition policy development and implementation.

Some resistance to "over regulation" or "professionalisation"

FDC is seen by many parents as providing a home-like alternative to centre based care. They value the fact that it is run by 'ordinary' people in an informal setting with the flexibility, informality and spontaneity of a home, rather than the formal, more organised systems of a centre. In this sense, the potential capacity of FDC to provide a culturally appropriate environment is particularly attractive to families when they can place their children in homes of carers from the same cultural and linguistic background.

There are both carers and parents who feel that FDC should not be forced to become like LDC centres with their programming, professional development, formal polices and rules, and there may be resistance to efforts that are seen to promote this.

Low levels of early childhood qualifications among carers and co-ordination staff

The last childcare census data suggest that only one quarter (26%) of Victorian FDC carers have any form of qualification and only half of these have early childhood specific qualifications, the rest having a range of certificate and degree based qualifications in other fields. A high proportion has no qualifications at all but have worked in the industry for three years (42%). A higher proportion of FDC co-ordination unit staff have qualifications (72%) but only 28% have early childhood specific qualifications.

There is considerable diversity in the motivation and the length of time carers stay in the role, and their preparedness to undertake early childhood qualifications or even in-service training. Some carers see FDC as a temporary means of earning an income while staying at home with their own children, or while adapting to a new country. Others view it as a long-term career or may see it as a stepping-stone to moving into professional early childhood sector jobs.

On the whole (and in contrast to LDC), there does not seem to be a strong culture of formal training, and there appears to some resistance to increasing formal training requirements. This lack of orientation to formal professional development has been described as particularly evident among older longer-term carers who have been in the business for ten or more years and seem to be resistant to changing ideas and practices.

Relatively low levels of compulsory pre- and in-service training

FDC programs have relatively low levels of compulsory training at induction and on going. Programs report between 16 and 25 hours required pre-service training at induction, and between 2 and 5 sessions (each session being of two hours duration) per year in-service training. A session on nutrition is generally part of the pre-service training and may or may not be presented by a dietitian, but there is rarely any nutrition focused in-service training. Training in relation to children and physical activity rarely features as a part of compulsory pre- or in-service training.

Limited capacity to access in-service training

Generally each FDC program funds the compulsory pre- and in-service training. Any additional training beyond this is the responsibility of the FDC carer. Carers clearly find it difficult to attend additional training beyond the compulsory training provided by the program co-ordination unit. Carers not only have to pay the fees, but if, as is common, training is only available during working hours, carers have to forgo income and make alternative arrangements for the children in their care. In the context of the low incomes most FDC carers earn, accessing additional in-service training is not only a problem in terms of timing but also cost and foregone income.

Lack of resources for co-ordination units is also a barrier. Most FDC programs state that they would like to provide more training, but cannot afford to do so. It is of concern that the federal government may be considering further decreases in funds for co-ordination units.

The one-year contract held by the Child Care In Service Training Consortium mentioned above (section 3.2.4) may be able to fill some of the gaps here in terms of providing customised, cheap and accessible training. However, the long-term future of the Consortium beyond 2003 is unclear.

Lack of knowledge of and access to existing resources

FDC carers and co-ordination unit staff appear to be relatively ill informed about resources that have already been developed to assist early childhood workers. This is partly a result of the low levels of training discussed above, but also because the resources for the early childhood sector have not been targeted to FDC. Thus knowledge of a number of useful resources such *What's There to Eat, Caring for Children* and *Relaxed and Social* was largely confined to the LDC sector.

Even FDC specific resources appear not to have reached the home-based carers. The recent resource *Good Food in Family Day Care*, whilst known about by some carers, has rarely been used as only one copy has been made available to each FDC Program. No funds have been allocated to facilitate dissemination and adoption. Clearly the extent to which carers can use the resource is thus extremely limited.

4.3.2 Long day care

While the development of healthy eating and physical activity policy has been part of the accreditation quality improvement system for several years, there are indications that implementation in LDC centres is still hindered by a number of factors.

Diversity and competitiveness of LDC sector

The LDC sector is significantly more diverse than the FDC sector with a range of management arrangements, and peak or representative bodies. This diversity and some difficulties in acting collaboratively across private and public centres can be described as presenting barriers to consistent information, policy development and action.

Lack of access to nutrition information, support and resources

While LDC workers generally have more information about healthy eating and nutrition resources than FDC workers, they still feel that they do not have access to the sort of information and support they need on an ongoing basis to meet quality improvement goals. Financial and time constraints restrict access to resources and training even when these are known. Many centres would like to be able to consult a dietitian around menu planning but cannot afford a commercial service or access a community one (Graham et al 2000, Gibbons et al 2000).

Impact of hygiene focus and food handling compliance

The mandatory food safety legislation in Victoria has been described as having an unfortunate impact in relation to healthy eating. The pressure to comply with the mandatory food handling legislation has led centres to spend on equipment, training and staff time to meet hygiene rather than nutrition goals. In particular, scarce staff development funds have had to be spent on food handling rather than nutrition courses.

Food safety legislation is also described as having limited the capacity of centres to provide learning opportunities for children via food preparation, handling, choosing, tasting and sharing food. Involvement of parents too in food preparation experiences has been restricted.

Food service in LDC centres appears also to have been affected. Concerns about meeting food safety standards or decisions not to spend time and money on trying to comply with legislation has led to the growth of contracting out food preparation. This has some drawbacks. Centre involvement in menu planning is limited, food types and quantities are not always appropriate, children have no opportunity to observe or participate in food preparation, centre kitchens are not registered and thus

theoretically cannot be used for food preparation of any kind even snacks, and staff have even fewer opportunities to apply any knowledge they may have around healthy eating.

Lack of trained cooks and training for cooks

Most LDC cooks have limited training in nutrition, the hours cooks are employed (in some cases only 2-3 hours a day) make it difficult to plan, shop, prepare and clean up, let alone experiment or expand menus or attend training programs. There is generally very little planning time to enable communication between centre staff and cooks, and to enable cooks to undertake adequate program planning around nutrition, (Allan 1998:3).

Recent research has shown that cooks in particular have relatively low levels of nutrition training and knowledge except in the area of food handling and hygiene, (Allan 1998:3; Pollard 1999; Gibbons et al 2000; Children's Health Development Foundation website 2002).

Competing resource and time priorities

Financial resources in LDC are extremely tight. In 1997 the federal government removed the operating subsidy for community based centres (to create 'a level playing field' between private and community centres), and financial pressures on local government has meant cuts in funds from that source.

There are reports of a negative impact on the provision of food services as a result of these financial cuts (Allan 1998:3), and of restrictions in spending on professional development. Competing priorities for staff time and financially have restricted the capacity of centres to send staff on training programs, and priority tends to be placed on areas such as food safety, health and emergency measures where there are mandatory requirements.

It is increasingly difficult to find and pay for backfilling positions while staff undertake training activities. Low pay scales in LDC are thought to be responsible for the difficulty LDC centres have in recruiting and retaining staff, and in finding relieving staff to back fill positions while permanent staff attend professional training or development activities.

Pressures on LDC staff during working hours in terms of the increasing level of responsibility, documentation, and meeting quality standards (combined with low pay scales) is said to be having an impact on morale and on unwillingness to undertake training outside working hours.

5. A strategic action framework to support healthy eating and physical activity policy and practice

The extent to which any early childhood service can improve children's eating and exercise patterns is influenced not only by policy and program development in the specific setting, but also by the extent to which the environment stimulates, complements and supports the development and implementation of policy and programs. The strategic action framework proposed here therefore reflects the need for action at the broad environment level, in the early childhood sector and in the specific settings.

The reader should be aware that this section provides a framework for strategic action, rather than a blue print for specific organisations or levels of government. Table 12 summarises the framework; a detailed discussion follows.

Table 12: Strategic action required to improve healthy eating (HE) and physical activity (PA) policy adoption in early childhood (EC) settings

Community Environment

1) **Action to develop a community environment that supports and stimulates healthy eating and physical activity policy and practices in early childhood settings:**
- implement a comprehensive public health program around healthy eating/physical activity/obesity prevention/wellbeing.

2) **Action to increase the availability of accessible, consistent and accurate information and advice about healthy eating and physical activity:**
- establish an information and advice service that is seen to be independent, credible and accurate, and is accessible in various forms including phone and on-line services,
- ensure the service is accessible to members of the public generally as well as professionals in all sectors including early childhood,
- ensure linkages between the service and other information lines with an early childhood focus such as Parent Line and the Maternal and Child Health Help Line.

Early Childhood Sector

1) **Action to raise the profile, status & capacity of EC sector:**
- reconsider use of the term 'childcare'; emphasise partnership with parents & family centred approaches,
- rethink resource provision in EC & recognise resource needs of EC services in low income & high need areas,
- undertake workforce review covering recruitment, retention, training & remuneration,
- link EC, HE & PA state & federal frameworks.

2) **Action to increase early childhood sector access to dietetic & nutrition services:** Review nutrition services to EC sector including the availability of:
- DHS funded specialist children's nutritionists,
- CHC-based EC focussed nutritionists,
- Pre- & in-service training in paediatric & children's nutrition & in health promotion/community education.

3) **Action to enhance the adoption of HE/PA policies & practices in EC services:**
- increase specificity & synchronise accreditation & licensing frameworks,
- fund the development of PA infrastructure,
- support incentive models,
- review EC training to increase HE/PA components,
- reconsider food safety regulations.

4) **Action to ensure adequacy of data & research on HE/PA in EC:**
- influence development of indicators in National Agenda for EC,
- access NQIAS data,
- mine existing state databases, eg MCH.

FDC/LDC Settings

1) **Action to increase the capacity of workers in FDC and LDC to adopt & implement HE and PA policy and programs:**
- develop sustainable, affordable, flexible training model,
- ensure training is culturally sensitive to need of both staff and families,
- establish training requirements for cooks,
- increase pre-/in-service training requirements for FDC carers,
- expand Start Right Eat Right incentive model across LDC & into FDC & include PA,
- develop training in relation to communication with parents.

2) **Action to ensure effective HE and PA resources are accessible, to LDC and FDC workers:**
- evaluate, disseminate & build on existing HE & PA resources,
- adapt effective LDC focussed resources to FDC,
- adapt effective resources to reflect cultural and linguistic diversity,
- develop new resources especially tailored for people of cultural and linguistic diversity and with low levels of literacy.

5.1 Actions in relation to the community environment

5.1.1 Action to develop an environment that supports and stimulates healthy eating and physical activity policy and practices in early childhood settings

Objective

To build a supportive environment in the broader community that raises awareness of and knowledge about the vital role of healthy eating and physical activity in children's development, and stimulates and complements the development of healthy eating and physical activity policy and practices in early childhood settings.

Suggested actions

Action by the Victorian Government and by public health agencies in government, non-government and private sectors that recognise that

- obesity and overweight and associated diseases such as diabetes, cardiovascular disease and some cancers are major health issues facing the Victorian community and Government,
- the promotion of healthy eating and physical activity within a whole of lifestyle approach are key factors in the prevention of obesity and overweight,
- to date there has not been a sustained, co-ordinated and consistent public health approach to the problem that has combined initiatives in both healthy eating and physical activity, and that
- a comprehensive public health program is required that builds on what we have learnt from other successful programs such as Quit, SunSmart, HIV/AIDS and safe driving. Specifically such a program should be characterised by the following features:
  - *Continuity*:- sustained over a lengthy period and with sufficient resources to ensure effectiveness over time.
  - *Co-ordination:* - well planned and well co-ordinated, with a clearly articulated and strategic vision.
  - *Credibility:* - run or co-ordinated within an organisational structure that has credibility at all levels including the general public, government, and the education, business and community sectors.
  - *Communication focus:* - underpinned by a targeted sustained mass media campaign that raises awareness, informs, educates and complements efforts in specific sectors such as early childhood and settings such as FDC and LDC.
  - *Research-based:* - grounded in, refined by and assessed against credible research that is epidemiological, scientific and behavioural.
  - *Multi-strategy:* - incorporates a wide variety of strategic approaches including mass media advertising, education, training, resource and policy development, social marketing, lobbying and advocacy, environmental and institutional change, incentives, penalties, legislation, etc.
  - *Multi-level and multi-setting:* - operates at many levels (individual, family, community, organisational, structural, environmental, government) and in many settings (across early childhood services, schools, training institutions, professional bodies in early childhood, dietetics, nursing and medicine, industry, the media, and with local, state and federal government).

In adopting such an approach based on a comprehensive and focussed public health program, the following actions are of particular importance in the promotion of healthy eating and physical activity in children:

- The adoption of a strategic focus on early childhood and children as a major aspect of the state-based comprehensive program, and the development of linkages between this program and key state and national frameworks that cover early childhood (the Broadband Redevelopment Process and the National Agenda for early Childhood), healthy eating (the Strategic Inter-Governmental Nutrition Alliance and the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan) and physical activity (the Strategic Inter-governmental Forum on Physical Activity and Health).
- A well funded, sustainable mass media campaign to tackle community awareness, attitudes and knowledge about healthy eating and physical activity in children, as a necessary precursor to behavioural change and a stimulant to organisational change.
- Consideration of the value of limiting or controlling fast food advertising during children's television viewing hours and on fast food promotional strategies.
- Strategies to support the fresh food industry and potentially to moderate the impact of the fast food industry.
- Education about food labelling so that members of the community can more readily identify ingredients such as fats and sugars.
- A re-evaluation of the focus and the resource commitment in mandatory food safety compliance, including a re-examination of the evidence for the current approach. Potentially there could be some redirection of some resources from food handling to education on healthy food and eating behaviour.
- Some investigation of the impact of the current focus on risk and risk management that appears to be having a limiting effect on physical activity opportunities for young children.
- Support for resourcing the development of active play facilities for all age groups, but particularly young children.

5.1.2 *Action to increase the availability of accessible, consistent and accurate information and advice about healthy eating and physical activity in early childhood*

Objective

To ensure the availability of accessible, consistent and accurate information and advice around healthy eating and physical activity generally and specifically in relation to early childhood for both professionals and parents.

Suggested actions

Consideration needs to be given to the development of a highly visible service accessible to all that can provide consistent, credible and accurate information and support around nutrition and physical activity as part of the comprehensive public health program. Such a service could, for example, be a telephone information and support line and accompanying electronic web-based service that covers all age groups, but with a well-advertised capacity in relation to children. The service should be run by a credible agency and act as a readily identifiable and easy-to-find source of information and advice about diet and physical activity requirements, about healthy eating and physical activity environments and behaviours, about strategies for educating on diet and physical activity, about where to access resources and where to go to seek specialist advice.

This initiative would not necessarily be focussed specifically on the early childhood sector. Ideally it would be a part of the comprehensive public health program around healthy eating and physical activity and would be promoted on a community-wide basis. The service would thus be open to work-

ers, parents and other members of the community and would need wide promotion to ensure that early childhood services and their representative and support agencies are fully aware of its existence and role.

Consideration should be given to ways in which such a line could be linked to existing information services for parents such as Department of Human Services Parent Line and the Maternal and Child Health Help Line.

5.2 Actions in relation to the early childhood sector

5.2.1 Action to raise the profile, status and capacity of the early childhood sector

Objectives

To ensure that the critical role of early childhood services in early intervention and as an interface between services and families is reflected in state and federal government policy around service funding, service provision and workforce planning.

To achieve state and federal government recognition of the particular importance of and extra demands placed on early childhood services in communities with high proportions of families on low incomes, from culturally and linguistically diverse backgrounds and of new arrivals, and also in the more remote and rural areas of Victoria.

To raise the profile of FDC as an important service option in the early childhood sector that has a particular role to play in relation to low income, recently arrived and culturally diverse families.

Suggested actions

It is suggested that the term early childhood services be used in place of the term childcare as a means of emphasising the importance of the early childhood years and the role played by organised settings for this age group. The use of the term 'childcare' tends to imply that these services are informal child minding services rather than formal early childhood development services. This terminology also perpetuates a child centred practice that inhibits the development of broader roles involving family centred practice.

In identifying early childhood services as key partners with parents in the development of young children, and the importance of maintaining high standards in these services, then we need to rethink the current under-resourcing of the area. At present, early childhood services are under considerable pressure as a result of a combination of increasing standards, decreasing financial support from governments, the need to be affordable to parents, and staffing difficulties due to low status, low wages and high demands.

In the light of this, consideration is therefore required in relation to the following:

- The role of government in the provision of financial support for early childhood services at local, state and federal level, the current split between federal and state government funding responsibilities between 'child care' on the one hand and 'preschool' on the other and the implications of this for an articulated and effective early childhood education system.

- The value of maintaining diversity in early childhood services, including government, community based, parent managed initiatives, operating on a for-profit and a not-for-profit basis, incorporating centre-based and home-based settings. This includes reviewing resource provision for different models of care.

- The current development of corporate childcare. The emergence of services with potential conflict of interest between quality services, profit and share market price may not be ideal. It is difficult to

be confident that market forces will ensure quality care when there is a dearth of places and long waiting lists in most areas and families have to take what they can get, rather than seek out high quality care.

- The need for a systematic review of workforce issues in relation to early childhood incorporating recruitment, professional standards, training and remuneration with a view to raising standards and ensuring stable rates of entry into and retention in the sector. On the whole pay rates for LDC staff and per capita fees for FDC carers need to rise to reflect the importance of the role and to attract significant numbers of people to enter and remain in the sector. This is also necessary to ensure that professional standards within the early childhood sector can be maintained and raised. In addition, an examination is needed of the level and content of training for early childhood workers and the extent to which this adequately covers healthy eating and physical activity. Both state and federal governments need to be involved in such a early childhood workforce review transcending the current separation of the sector into childcare and preschool fields.
- The need to ensure that FDC has a future as a flexible, home-based service at the same time as providing quality care for children. A balance needs to be retained between an informal, homely care setting, reasonable standards of care provided by non-professional carers, and affordable care. Too high a set of standards, too high a set of fees, too high demands for "professionalism" will drive both carers and families into the informal sector where it will be difficult if not impossible to assess standards and to support development.
- The resource and support issues involved in providing flexible, sensitive and quality care in areas with a high proportion of low income families, or of families from diverse cultural and linguistic backgrounds or of newly arrived families as well as the availability of accessible and high quality care in remote and rural parts of Victoria.

To address these issues it is important that the Victorian Government participate actively in the federal government's Broad Band Redevelopment Process in order to:

- ensure increased funding to support early childhood services generally,
- secure specific funding earmarked to support services operating in areas of social, geographic and demographic stress, and
- ensure that a sustained, accessible, flexible and appropriate training provision is maintained for the early childhood sector.

Also that the Victorian Government participate actively in the federal government's development process for a national agenda for early childhood, and specifically to:

- argue for an increase in the profile of healthy eating and physical activity initiatives as a key part of obesity prevention in early childhood,
- argue for environmental initiatives to complement and stimulate healthy eating and physical activity in early childhood,
- contribute to the development of key indicators and data collection processes for monitoring progress in these fields, and
- assist in developing links between the national frameworks in healthy eating and physical activity and the emerging early childhood agenda or framework.

5.2.2 *Action to increase early childhood sector access to dietetic and nutrition services*

Objective

To ensure that dietetic and nutrition information, support and advice are readily available to early childhood services and are delivered within an education, health promotion and public health framework.

Suggested actions

A review needs to be undertaken of the availability of nutrition services specifically geared to the early childhood sector. This could include consideration of:

- The decrease in specialist children's nutritionists in DHS regional offices and the increasing emphasis on clinical services in current job descriptions.
- The possibility of funding early childhood focussed nutritionists and dietitians in community health as part of the comprehensive public health approach to obesity prevention. A precedent exists in this regard with Home and Community Care funded dietitians who have a specific focus on ageing and disability.
- The availability of pre-service and in-service training with a specific focus on paediatric and children's nutrition, and
- The availability of pre-service and in-service training relating to public health, health promotion and community education.

5.2.3 *Action to enhance the adoption of healthy eating and physical activity policies and practices in early childhood services*

Objectives

To ensure that all early childhood services adopt both healthy eating and physical activity policy statements and take active measures to implement these policies.

To ensure all early childhood sector staff understand and can implement quality standards around healthy eating and physical activity required by the national accreditation system and the state licensing system.

Suggested actions

Consideration should be given to ways of synchronising the content of the national accreditation and the state licensing frameworks so that they reinforce and support one another. The intention by the state government to modify the Children's Services Act (1996) could be an opportunity to achieve this.

In addition to greater synchronicity, the accreditation and the licensing systems also need to increase the specificity of healthy eating and physical activity requirements, for example:

- Greater specificity is required as to what is "nutritious food", what constitutes "current information on nutrition", what are "healthy eating habits", what sort of "nutrition training" staff should have, what does "evaluation of menus against nutrition guidelines" actually mean.
- Part of accreditation as a high quality service could involve the assessment of all menus by a dietitian. Such a requirement could act as a spur to changes identified under section 5.2.2 above in relation to the accessibility of early childhood dietetic advice and support.
- More explicit requirements are needed in relation to the training in nutrition of early childhood staff generally and of cooks in particular. Increasing standards in this area could stimulate the

development of appropriate, affordable and accessible training to fulfil this requirement (see section 5.3.1 below).

- Early childhood staff identify that they find communication with parents problematic when issues such as nutrition, family eating habits, physical activity, overweight and obesity are involved. The development and demonstration of expertise in this area could well be included as indicators of high quality.
- Accreditation and licensing frameworks are both deficient in the area of physical activity. A number of additional aspects could be included, for example, a requirement for a policy statement around physical activity, guidelines for the ratio of indoor and outdoor space and the layout, equipment and design of the play space, the allocation of time for active outdoor play and the inclusion of age appropriate physical activity sessions. Quality care also needs to include early childhood staff having training in the planning and provision of age appropriate physical activity. Resources that address this are also needed.

If standards are raised around physical activity programs and equipment, consideration should be given to providing financial support and incentives for early childhood services to adapt indoor and outdoor facilities for active play to meet these standards.

Subject to the evaluation results, the implementation of the Start Right Eat Right (SRER) award model into Victoria should receive on-going support. Consideration should also be given to extending the model to FDC on the basis of evidence from a forthcoming trial in Western Australia. Ways in which SRER or a similar program could be developed to include physical activity standards should also be explored.

A review of the impact of the Food Safety Act in early childhood services should be undertaken including:

- evidence of the need for the current level of food safety requirements in early childhood services,
- evidence of the effectiveness of mandatory food handling methods in reducing the transmission of disease, and
- the impact on early childhood services including education, socialisation and child development issues as well as hygiene.

Consideration needs to be given to increasing the extent of healthy eating and physical activity components in childcare training courses. If the curriculum is too crowded, this may include a decrease in emphasis on food handling to enable an expanded emphasis on healthy eating and physical activity.

5.2.4 *Action to ensure adequacy of data and research around healthy eating and physical activity in early childhood services*

Objective

To ensure the availability of adequate base line and trend data on which to plan and implement healthy eating and physical activity initiatives in relation to children generally and in early childhood services specifically, AND to assess their effectiveness.

Suggested actions

The federal government's National Agenda for Early Childhood aims to develop indicators of children's progress, and national outcome and reporting procedures. The finalised agenda may have a useful contribution to make to tracking diet and fitness trends among children, assessing overweight and obesity trends in children, and evaluating the extent to which healthy eating and physical activity initiatives have been adopted. Appropriate input needs to be made into the development of the National Agenda to ensure that appropriate indicators are adopted.

One potential source of data is the national accreditation system. This system could provide useful aggregated data on policy and program adoption and implementation in specific areas such as healthy eating and physical activity. Action should be taken to increase the availability of such data.

Potentially, the state based inspection and licensing system could also provide information about the extent to which early childhood services are meeting or exceeding guidelines in relation to healthy eating and physical activity. This too needs exploration to ensure the potential is exploited.

Finally, existing databases, such as the maternal and child health system, should also be explored for their capacity to provide long-term trend data.

5.3 Actions required in relation to family day care and long day care

5.3.1 *Action to increase the capacity of workers in FDC and LDC to adopt and implement healthy eating and physical activity policy and programs*

Objectives

To raise the profile of staff in FDC and LDC as important players in modelling healthy eating and physical activity to children and families, in supporting, encouraging and informing families about appropriate behaviour and where necessary, linking families to specialist services.

To increase the capacity of FDC and LDC staff to adopt such a family centred approach to healthy eating and physical activity and to ensure that training is appropriate, accessible and affordable for LDC workers including cooks, and for FDC carers and co-ordination staff.

Suggested actions

Ensure that there is a sustainable model in place for the delivery of affordable, accessible, flexible and customised training to FDC and LDC workers. The current training consortium of Community Child Care and others may achieve this but it is funded for one year only and a long-term commitment is required to ensure sustainable development of such a training model.

Extending and expanding the Start Right Eat Right model across LDC (and potentially FDC) will also support the provision of valuable training for cooks and staff in LDC.

It is vital that any training is culturally sensitive. Firstly, training has to be delivered in such a way that it is accessible to FDC and LDC staff from culturally and linguistically diverse backgrounds. And sec-

ondly, training has to be culturally sensitive in that healthy eating and physical activity strategies must be sensitive to and reflective of the diversity of cultures in the community.

There are a number of projects where important knowledge about culturally sensitive training has already been accumulated, for example, the Moonee Valley Child Nutrition Alliance project, the Victorian Co-operative on Children's Services for Ethnic Groups training for ethnic health workers, the Victorian Foundation for Survivors of Torture resource *Easing the Transition* and the work of the FKA Multicultural Resource Centre.

The national accreditation system and state licensing system needs to be modified to increase quality standards around:

- pre- and in-service training for FDC carers in healthy eating and physical activity,
- culturally sensitive training for carers both from and working with diverse communities,
- training for LDC cooks in nutrition, and
- evidence of confidence and skills in communication with parents.

Ensure that training is developed and offered to LDC staff and FDC carers in how to meet the federal and state accreditation and licensing requirements (enhanced as per these recommendations) especially in relation to communication with parents in general and also specifically in relation to issues of healthy eating, physical activity and obesity and overweight.

Reconsider the extent of healthy eating and physical activity components in early childhood training courses as suggested above in section 5.2.3.

5.3.2 Action to ensure effective healthy eating and physical activity resources are accessible and relevant to FDC and LDC workers

Objectives

To ensure that knowledge about and use of existing healthy eating and physical activity resources is widespread in FDC and LDC and in the agencies that represent and resource them.

To ensure that healthy eating and physical activity resources are available to meet the needs of carers and families with low literacy levels and from diverse cultural and linguistic backgrounds.

Suggested actions

That the focus be on building on existing healthy eating and physical activity resources rather than on developing new resources. Specifically this would involve the provision of funds to ensure the development, adaptation and dissemination of a number of key existing resources, the provision of support and training packages to accompany dissemination, and evaluation of their effectiveness.

Existing resources include two resources specifically developed for the FDC setting:

- *Good Food in Family Day Care* and
- *Active Care for Children in Family Day Care.*

In addition, there are several existing resources with a specific LDC focus but potentially relevant to FDC. Where necessary adaptation should occur to make the following resources relevant to FDC:

- *Caring for Children: Food, nutrition and fun activities*
- *What's There to Eat*
- *Start Right Eat Right program*
- *Filling the Gap Nutrition Tip Sheets*
- *Relaxed and Social: A positive approach to children's eating.*
- *Early Childhood Physical Activity Guidelines.*

Some adaptation is required of existing resources (and potentially development of new resources) in order to ensure they are accessible to people with limited literacy or English language skills. This process could be built on existing experience derived from recent work in some of the National Child Nutrition and the Primary Care Partnership Projects in Barwon and Colac, as well as work done by the Victorian Co-operative on Children's Services for Ethnic Groups, the Victorian Foundation for Survivors of Torture and the FKA Multicultural Resource Centre.

Appendix I Eat Well Victoria Partnership

The Eat Well Victoria Partnership (EWVP) was established by the Department of Human Services (DHS) in early 2001. The membership of EWVP includes key Public Health Nutrition stakeholder organisations and individuals in Victoria. Stakeholder organisations include:

- DHS
- Dietitians Association of Australia
- Nutrition Australia
- National Heart Foundation
- Diabetes Australia - Victoria
- VicHealth
- Deakin University
- Monash University
- The Cancer Council Victoria

Membership also includes individuals with expertise in public health nutrition relevant to the groups' current work focus.

The EWVP believes that a coordinated and shared approach to public health nutrition will provide greater capacity and opportunity for change over time. The ultimate purpose is to create an environment to facilitate active contribution to the improvement of health and the reduction of the burden of diet-related illness, disease, disability, and early death in an equitable way across communities. EWVP is a strategic level group and it is anticipated that the combined effort of the group will result in more effective advocacy and a common vision to address priority issues. The Terms of Reference for the EWVP are based on the national nutrition strategic framework developed by the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) and detailed in Eat Well Australia: A Strategic Framework for Public Health Nutrition, 2000 – 2001.

Chair:

- *Robyn Charlwood:* Executive Director National Heart Foundation of Australia (Victorian Division)

Members:

- *Andrea Bryce:* Dietitians Association of Australia
- *Lucinda Dobson*: Executive Officer, Nutrition Australia
- *Kay Gibbons*: Chief Dietitian, Manager Food and Nutrition Services, Royal Children's Hospital
- *Veronica Graham:* Statewide Public Health Nutritionist, Healthy Living Team, Department of Human Services
- *Greg Johnson:* Chief Executive, Diabetes Australia – Victoria
- *Associate Professor Malcolm Riley:* Head, Nutrition and Dietetics, Department of Medicine, Monash Medical Centre
- *Yvonne Robinson:* Director of Programs, Victorian Health Promotion Foundation
- *Craig Sinclair:* Deputy Director, Cancer Education, The Cancer Council of Victoria
- *Professor Boyd Swinburn:* School of Health Sciences, Deakin University
- *Rowland Watson:* Team Leader, Healthy Living Team, Department of Human Services
- *Bev Wood:* Consultant

Appendix II Organisations & individuals consulted

- National Family Day Care Council of Australia
- National Childcare Accreditation Council of Australia
- Family Day Care Victoria Inc: Resource Unit
- Family Day Care Victoria: peak body representing Victorian FDC Programs
- Victorian Home Based Carers Association
- Session at bimonthly meeting of Family Day Care Victoria (23 Regional Program representatives in attendance)
- Session at the Annual State Family Day Care Conference (150 FDC co-ordination units staff and carers attended)
- Session at the monthly meeting of the Child Care Co-ordinators' Association (35 Co-ordinators attended)
- Municipal Association of Victoria/DHS: Community Care Committee: various members Community sector management
- Kindergarten Parents of Victoria – Food Facts for Preschoolers
- Early Childhood Consultant, Uniting Care
- Melbourne University Children's Services
- Moreland City Council Children's Services Co-ordinator
- Moreland City Council Family Day Care Team Leader
- Kilmany Family Care
- East Gippsland Family Day Care
- Central Goldfields Children's Centre
- Wyndham City Council Family Day Care
- Casey Family Day Care
- Monash Family Day Care
- Hobsons Bay City Council Family Day Care
- Geelong City Council Family Day Care
- East Melbourne Child Care Co-operative
- Community Child Care: Children's Services Resource consultants
- Lady Gowrie Training and Resource Centre for Child Care Centres: Co-ordinator of Accreditation Advisory Service
- Victorian Parenting Centre
- Children's Services Resource and Development Officers Association
- Playworks Resource Centre for Children with Disabilities
- Victorian Aboriginal Education Association Inc Early Childhood Specialist Group
- Victorian Foundation for Survivors of Torture
- Victorian Co-operative on Children's Services for Ethnic Groups (VicSEG)
- Free Kindergarten Association's Multicultural Resource Centre
- Uniting Care Mobile Childcare Services
- Barwon Primary Care Partnership, South West Early Childhood Nutrition Project
- Glenelg Outreach Primary Care Project
- Colac Otway Community Health Project
- Child Care Co-ordinators' Association
- Childcare Centres Association of Victoria
- Victorian Private Child Care Association
- Department of Human Services including:
    - Children's Services generally
    - Early Years
    - Best Start
    - Food Safety
    - Disability Services

- Training and Development Co-ordinator, Sentinel Site for Obesity Prevention, Deakin University School of Health Sciences, convenor Barwon Regional Nutrition Network
- Regional Health Promotion Officer, Barwon Region
- Deakin University
- Monash University
- Swinburne University: Department of Child & Family Studies
- University of Melbourne: Department of Language & Education Development
- Victorian TAFE Child Care Studies Co-ordinators Network

Officers involved in key projects in FDC and LDC including:

- Good Food in Family Day Care: A Food and Nutrition Information Kit.
- Healthy Food Choice in Family Day Care: South Australian Department of Education and Children's Services
- Start Right Eat Right WA and SA
- Moonee Valley Child Nutrition Alliance
- National Child Nutrition Projects
- Start Right Eat Right Victorian Pilot at Lady Gowrie Training Centre
- Active Care: Physical Activity in FDC Project
- Western Region Community Health Centre National Child Nutrition Project
- Primary Care Partnership – South West "Food to Grow On
- Food Facts for Preschoolers
- Take Five Warrnambool

Dietitians and Nutritionists

- Andrea Bryce: Dietitians Association of Australia
- Bev Wood: Consultant, member of Eat Well Victoria Partnership
- Lucinda Dobson: Executive Officer Nutrition Australia
- Veronica Graham: Statewide Public Health Nutritionist Healthy Living Team, Department of Human Services
- Kay Gibbons: Chief Dietitian Royal Children's Hospital
- Susan Baudinette: Chief Dietitian, Nutrition Department, Southwest Health Care, Warrnambool
- Katrina Doljanin: Convenor, Dietitians Association of Australia (Vic Branch) Public Health and Community Nutrition Interest Group; Community Dietitian North Yarra Community Health Centre
- Karen Campbell: Deakin University lecturer, doing a PhD on children's eating behaviour
- Janet Torode: Barwon Regional Specialist Children's Services Dietitian and member of the Dietitians Association of Australia (Vic Branch) Public Health and Community Nutrition Interest Group
- Linda Dodimead: Eastern Region Specialist Children's Services Dietitian (based in Ringwood in the Outer East Team)
- Liz Burns: Eastern Region Specialist Children's Services Dietitian (based in Boxhill in the Inner East Team)
- Sally Girvan: Northern Region Specialist Children's Services Dietitian
- Anne Netherway: Dietitian Manningham Community Health Service, member of the Dietitians Association of Australia (Vic Branch) Public Health and Community Nutrition Interest Group
- Judith Myers: Clinical Specialist Dietitian and Lactation Consultant, Department of Nutrition and Food Services, Royal Children's Hospital
- Julie Woods: Monash University Department of Nutrition and Dietetics
- Jane Winter/Helen Matters Deakin University School of Health Sciences
- Sue Milner: State Public Health Nutritionist for Disability DHS
- Sue Lancaster: Dietitian involved in project around autism across the Disability and Community Care Divisions of DHS
- Sharon Muller: Western Region Community Health Centre
- Beth Scholes: Barwon Primary Care Partnership, South West Early Childhood Nutrition Project
- Kerin Barnard & Dianne Storer: Community Dietitians Bendigo Health Care Group

Appendix III Project advisory group

Ms Robyn Charlwood
Executive Director
National Heart Foundation of Australia (Vic Division)
411 King Street
West Melbourne VIC 3003

Ms Susan Baudinette
Chief Dietitian
Nutrition Dept
South West Healthcare
Ryot Street
Warrnambool Vic 3280

Ms Lee Choon Siauw
Senior Project Officer
Victorian Health Promotion Foundation
15-31 Pelham Street
Carlton VIC 3053

Ms Veronica Graham
Statewide Public Health Nutritionist
Healthy Living Team
Department of Human Services
Level 16, 120 Spencer St
Melbourne, Vic 3000

Ms Kay Gibbons
Manager Food and Nutrition Services
Royal Children's Hospital
Flemington Road
Parkville Vic 3052

Professor Tony Worsley
School of Health Sciences
Deakin University
221 Burwood Highway
Burwood Vic 3125

Appendix IV Sector feedback on the draft document

1) **Community Child Care:** support agency for community owned early childhood services - Melodie Davies & Nicole Dalgleish: Children's Services Resource Consultants

2) **Community Care Partnerships Working Party:** joint working party consisting of Department of Human Services and the Municipal Association of Victoria and local government representatives. The working party considers issues in relation to family, youth and children's services - Jan Barrett, Manager Children's Services, City of Moreland

3) **Childcare Centres Association of Victoria:** "an association of Proprietors primarily for the Private Child Care Industry. The Association also provides membership services to non-private childcare organisations and to individuals wanting to get into the child care industry." - Frank Cosmano Executive Officer

4) **Moonee Valley Child Nutrition Alliance:** National Child Nutrition project - Mary Stewart, Project Officer

5) **Start Right Eat Right Pilot Project:** nutrition award program for LDC centres - Sue Kleve, Co-ordinator of Start Right Eat Right

6) **Family Day Care Resource Unit:** Sally Cooper, Executive Officer

7) **Family Day Care Victoria Executive Committee:** chaired by Debbie Elear and comprises a co-ordination unit representative of FDC from each Region

8) **Children's Services Co-ordinators' Association: Executive Committee:**
Petra Hilsen Spokesperson for the Executive and Director of East Melbourne Childcare Co-op, Yarra Park Children's Centre & Powlett Reserve Children's Centre

9) **National Child Nutrition Projects:** Liz Stewart Department of Health and Ageing Project Officer and representatives of all Victorian NCNPs, Deakin University Cluster Evaluation and Victorian Department of Human Services

Appendix V Key nutrition resources

- Recommendations for Nutrition and Physical Activity for Australian Children, *Medical Journal of Australia* Vol 173 7 August 2000.
- *Food for Under 2's*, The Australian Nutrition Foundation 1996.
- *Nutrition for Toddlers and Young Children*,The Australian Nutrition Foundation 1996.
- *Dietary Guidelines for Children and Adolescents*, National Health and Medical Research Council, Australian Government Publishing Service, 1995 (currently under revision).
- *What's There to Eat? The practical guide to feeding families, A resource for early childhood service providers about food and nutrition and how to encourage healthy eating in families*, Victorian Department of Human Services 2001.
- *Caring for children: Food nutrition and fun activities, A practical guide to meeting the food and nutrition needs of children in care*, NSW Health Department 1996.
- *Easing the Transition: A resource book for health and settlement workers supporting those recently arrived in Australia to maintain a healthy diet and lifestyle*, Australian Foundation for the Survivors of Torture 2000
- *Relaxed and Social: A positive approach to children's healthy eating, a booklet for child care staff building on the "Sharing a picture of children's development communication framework"* Centre for Community Child Health, Royal Children's Hospital, Australian Dairy Corporation 2000.
- *Start Right Eat Right Award: A guide for long day care centres.* 2002-2003 Lady Gowrie Child Centre, Victorian Department of Human Services.
- *Food Facts for Preschoolers Program.* Kindergarten Parents of Victoria. One of the federal government Department of Health and Ageing National Child Nutrition Projects 2001-2003.
- *Menu Planning for Childcare Centres,* Nutrition Australia 1998.
- *Food and Nutrition Accreditation Guidelines for Child Care Centres*, Nutrition Australia 2002.
- *The Cook's Cookbook: The cookbook for childcare centre cooks, by childcare centre cooks*, The Australian Nutrition Foundation 2000.
- *Nutrition and Food Hygiene Course for Child Care Centres Video,* The Australian Nutrition Foundation.
- *Good Food in Family Day Care: A food and nutrition information kit*, National Family Day Care Council of Australia, South East Sydney/Central Sydney/South Western Sydney Area Health Services and Dept Health and Aged Care 2002.
- *Filling the Gap Child Nutrition Tip Sheets funded by Victorian Department of Human Services and developed by Department of Nutrition and Food Services, Royal Children's Hospital:*
  - Food in the first year of life
  - Why no sweet drinks for children
  - Healthy eating for young toddlers
  - Healthy eating for older toddlers
  - Healthy eating for preschoolers
  - Healthy eating in the primary school years

And three other Tip Sheets are under development, School lunches, Child obesity, Fruit and vegetables.

- *Positive Parenting Tip Sheets* developed by the Victorian Parenting Centre:
  - Independent Eating
  - Mealtime Problems
  - Many others on a variety of topics under headings of General Parenting, Infants, Toddlers, Preschoolers and Primary Schoolers. Topics include Whining, Disobedience, Sharing, Tantrums, Interrupting etc.

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