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Integrating Universal Healthcare in Early Childhood Education for Sustainable Community Development (IHSD)

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Abstract- The early years of life are crucial to establishing a sound foundation for cognitive, social, emotional and physical development for the rest of children's lives. Universal health coverage and nurturing care framework policies ensure holistic child care, however, many children in Siaya County seem to lack holistically child care in their education as we spend our energies on treatment rather than prevention services which are more cost effective. The major question this study sought to respond to was "How do preschools integrate universal health care services in early childhood education? This is an action research design utilizing both quantitative and qualitative tools of data collection and is informed by humanizing child development theory as proposed by Eugene M. De Robertis, 2008.The participants for this project included 1400 pre-school teachers. Instruments of data collection included questionnaires for pre-school teachers, interview schedule for teachers and document analysis of curriculum, teacher preparation materials, and health care records. Quantitative data was analyzed using descriptive statistics, while qualitative data utilized thematic analysis approach.

Keywords: *child development; nurturance; healthcare; universal; early childhood education.*

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Integrating Universal Healthcare in Early Childhood Education for Sustainable Community Development (IHSD)

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Abstract- The early years of life are crucial to establishing a sound foundation for cognitive, social, emotional and physical development for the rest of children's lives. Universal health coverage and nurturing care framework policies ensure holistic child care, however, many children in Siaya County seem to lack holistically child care in their education as we spend our energies on treatment rather than prevention services which are more cost effective. The major question this study sought to respond to was "How do preschools integrate universal health care services in early childhood education? This is an action research design utilizing both quantitative and qualitative tools of data collection and is informed by humanizing child development theory as proposed by Eugene M. De Robertis, 2008.The participants for this project included 1400 pre-school teachers. Instruments of data collection included questionnaires for pre-school teachers, interview schedule for teachers and document analysis of curriculum, teacher preparation materials, and health care records. Quantitative data was analyzed using descriptive statistics, while qualitative data utilized thematic analysis approach. The study revealed that most of components on health and safety included in the early childhood education at preschool centers are at the level of inadequate. Teachers indicated that they know what to do in cases of emergency but lack written policy guiding their actions. The study recommends for enabling policies, supportive services, empowered communities and caregivers' capacity building including preschool teachers.

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I. Introduction

Early child development sets the foundation for lifelong learning, behavior, and health. The experiences children have in early childhood shape the brain and the child's capacity to learn, to get along with others, and to respond to daily stresses and challenges (Unicef, 2017). Beginning in the last trimester of the prenatal period, brain pathways are formed by developing new connections (Richter LM, Daelmans B, Lombardi J, et al, 2017). This growth increases after birth and follows a predictable sequence (McCain, Mustard & Shanker, 2007); National Scientific Council on the Developing Child, 2007). At birth, newborns start with very similar brains and brain structures. There are "sensitive periods" during a child's development, when the wiring of the brain for specific abilities is established (Couperus & Nelson, 2006; Black M, Walker P, Fernald L, 2017). Providing responsive, nurturing and stimulating experiences establish the wiring of the brain connections. Children who are well supported and nurtured physically, emotionally, socially and intellectually will develop a multitude of neural connections that will serve them well throughout their life course. (Gertler P, Heckman J, Pinto R, et al, 2014) A child's interest and curiosity are the motivators that create new connections to acquire new skills. Each new skill builds on a skill already learned. (Berk, L. & Roberts, W. (2009). The child's environment can support and enhance his interest and curiosity. Early brain development establishes a child's social competence, cognitive skills, emotional well-being, language, literacy skills, physical abilities and is a marker for well-being in school and life resiliency (Blair, 2002).

There are many interrelated factors which influence a child's overall healthy development. Education, health, social status, access to quality health and social services, housing, access to stimulating early learning environments, adequate nutrition, clean water, and a secure and nurturing parent-child relationship all play a role. Given the importance of the early years in shaping a child's brain development, every child has a right to an enriched and supportive environment in order to reach his full potential. (Yousafzai AK, Lynch P, Gladstone M, 2014) Families of young children need access to health care, quality and affordable child care, parenting supports, and education within their local community. The concept of a 'community hub' is not a new one. More than a decade ago, McCain and Mustard (1999) called for centres which operate using "a 'hub and spoke' model" (p. 17), to provide "seamless supports and access to early intervention for families in need" (p. 17). In a few communities, this holistic, seamless approach has been used with success (e.g., Toronto First Duty sites, integrated Best Start sites). But the goal of "An integrated continuum of early child development and parenting centres to serve all Ontario children" (McCain & Mustard, 1999) is still a work in process.

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To meet the needs of children and families, an integrated and holistic approach to service delivery is essential. In keeping with this holistic approach to service delivery, care must be taken to address the needs of the whole child. Universal health coverage can generate significant health and economic benefits to populations (World Bank. 2005) and enable governments to reduce inequity. (Nicholson D, Yates R, Warburton W, et al. 2015) Despite costing more to national governments in the short term, UHC pays back its initial debt to national economic growth in multiples. Access to healthcare is important for women and children, including establishing breastfeeding and immunization, and contributes to early childhood development. The Lancet Commission on Investing in Health in 2013 found that the economic benefits of achieving a grand convergence of global health outcomes for infectious diseases and for maternal and child health would outweigh the costs by a factor of between 9 and 20 over 20 years from 2015 to 2035. (Lancet2013). When implemented well UHC can contribute to nation-building (Millwood, 2008; Stuckler D, et al 2010; McKee M, et al 2013).UHC has an important role to play in global health security efforts through building a strong frontline health system, strengthening access to vital services and funding robust surveillance systems. (Alsan M, et al 2016; Kutzin J, Sparkes SP 2016; WHO, 2016).

Within this UHC and holistic concept of healthy child development, paying attention to the social, emotional, physical, cognitive and language domains of each child's development serves as a guide for professionals to ensure all areas of a child's development are included (Campbell F, Conti G, Heckman J, 2014). To achieve this, the Nurturing Care Framework provides a roadmap for action. It builds on state-of-the-art evidence about how early childhood development unfolds and how it can be improved by policies and interventions (Britto P, Lye S, Proulx K, 2017). It outlines why efforts to improve health, well-being and human capital must begin in the earliest years, from pregnancy to age 3; Nurturing care is the set of conditions that provide for children's health, nutrition, security and safety, responsive care giving and opportunities for early learning (Stoltenborgh M, et al 2013). Nurturing children means keeping them safe, healthy and well nourished, paying attention and responding to their needs and interests, encouraging them to explore their environment and interact with caregivers and others. (Lucas JE, Richter LM, Daelmans B, 2018). To reach their full potential, children need the five components of nurturing care. These are Good health, adequate nutrition, responsive care giving, security and safety and opportunities for early learning. (Norman R et al, 2012).

II. Statement of the Problem

Although decreased child mortality, relatively improved nutrition and school enrolment may give a picture that the World is on track on its promises for children (Chan, M. (2013). However, many of the children who are surviving now, are not achieving their full developmental potential (World Health Organization; 2017). According to an estimate, in developing countries around the world, 200 million children under 5 years of age are not achieving their potential. Moreover, 57 million children around the world are out of school and thus at risk. Moreover, if one digs deeper, beyond national averages, there are widening disparities among regions, countries and within countries, based on wealth, gender, and geographic location. This study was based on domains of nurturing care which are; health, nutrition, responsive care, security and safety, early learning. This study concentrated on health and safety as an aspect of Nurturing care and sought to respond to the question. "How do preschools integrate universal health care services in early childhood education in Siaya County"

a) Purpose of the study

To establish the extent to which preschools integrate universal health care services in early childhood education in Siaya County

Objectives (s)

(i) To establish how preschools integrate universal health care services in early childhood education.
(ii) To find out which elements of universal health care services are being integrated by preschools in early childhood education?

Research Question

(i) How do preschools integrate universal health care services in early childhood education in Siaya County?
(ii) What elements of Universal health care services are being integrated in early childhood education?

III. Methodology

a) Research Design

The study adopted the Convergent Parallel Design. According to Tashakkori and Teddlie (2003), the convergent parallel design (also referred to as the convergent design) occurs when the researcher uses concurrent timing to implement the quantitative and qualitative strands during the same phase of the research process, prioritizes the methods equally, and keeps the strands independent during analysis and then mixes the results during the overall interpretation. For example, an investigator might collect both quantitative correlational data as well as qualitative individual or group interview data and combine the two to best understand participants' experiences. The data analysis consists of merging data and comparing the two sets of

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data and results (Creswell & Plano Clark, 2011; Morse & Niehaus, 2009).

b) Population and Sample

The target population for the study was 700 Preschools. That is, 700 ECD Centres, 1400 ecde teachers. The study used stratified random sampling to select ECDE teachers. Stratified random sampling identifies sub-groups in the population and their proportions and select from each sub-group to form a sample (Cooper and Schindler, 2009).Stratified random sampling was found appropriate for this study as it ensures that each sub-group is proportionately represented. In total, 140 Ecde teachers participated in the study having taken 10% of the target population according to Kothari 2011; Wolverton, 2009; Kothari & Guaray, 2015, and purposive sampling by taking 2 teachers from each Sub-County totaling to 12 teachers for interview.

c) Research Instruments

The instruments used in the study were questionnaires administered to ECDE teachers and interview schedule administered to 12 teachers.

d) Data Analysis

Data was analyzed both quantitatively and qualitatively. Quantitative data was analyzed using descriptive statistics, which quantitatively describes the main features of a collection of information, or the quantitative description itself. The Descriptive statistics aim to summarize a sample, rather than use the data to learn about the population that the sample of data is thought to represent. On the other hand, qualitative data from interviews was analyzed using the thematic framework.

IV. Findings and Discussion

Table 1: Percentage frequency response on Health and safety

ITEM	IA	M	G	E
Written policy on what to do if a child gets sick	90	10	0	0
Written Rules concerning exclusion for contagious illness	89	11	0	0
Records of immunization and other health information	4	80	16	0
Staff have had physical exam and TB test within 2 years	96	4	0	0
Area set aside for sick child.	89	11	0	0
Policy on reporting a child who has been abused or neglected	91	0.9	0	0
Written policy concerning a child's physical or mental health.	100	0	0	0
Children allergies and medication schedule posted for staff use	100	0	0	0
Written safety and emergency procedures.	80	16	4	0
Staff trained in safety and emergency procedures.	89	11	0	0
Written specific emergency evacuation procedures.	90	10	0	0
First aid kit accessible	90	10	0	0

Key: IA= Inadequate; M=Moderate; G=Good; E=Excellent

From table one, 90% of teachers have inadequate written policy on what to do if a child is sick. This concurs with interviewed teachers who stated that they have no written policy. Thus "*we know what to do when a child is sick but we have no written policy". On the second item on* written Rules concerning exclusion for contagious illness, 89% of the teachers indicated inadequate. Interviewed teachers also reported that they have no written rules concerning exclusion for contagious illnesses. A representative statement "*we just tell parents not to allow a child come to school but we have not developed a policy*"

On records of immunization, 80% of teachers moderately had immunization record, however, document analysis revealed that there were only ticks on each of the imunizable diseases such as whooping Cough, Measles, Tuberculosis, Diphtheria, Tetanus and Poliomyelitis without indicated when it was done. A representative statement was that "*we ask parents whether the child is immunized and we tick, but we don't keep their original immunization cards*"

On whether staff have had physical exam and TB test within 2 years, results indicated 96% inadequacy. This was supported by interviewed teachers who noted that they are hearing physical examination from the researcher "*am hearing about physical exam and TB test from you, we don't have that… all we need is certificate in ECD*". On setting place a side for sick child, 89% of teachers reported inadequacy. This statement is in agreement with interviewed teachers who noted that there is no separate room for sick children. A representative statement "*Space is what we lack, we have no additional room for sick child. We just monitor in class as we wait for parent*

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to pick him or her" On mechanism for reporting abused or neglected child, 91% reported inadequate. This agrees with interviewed teachers who stated that they have no way of knowing a child that is a bused. "*if we detect something is wrong, we call a parent, we are not trained on how to detect child abuse or neglect, in-fact for neglect we only observe whether a child is hungry or sad"* on the policy on physical and mental health, the results indicate 100% inadequate. This concurs with qualitative data that revealed teachers do not know how to deal with physical or mental health. On allergies and medication schedule, the result reported 100% inadequate. This concurs with interviewed teachers that indicated there were no posting of allergies and other health problems for staff information" *we don't follow medication schedule strictly, we have a lot to handle in class that sometimes we forget"* on written safety and emergency procedures, the findings reported 80% inadequate and 16% moderate. This means that majority of teachers have no written emergency procedures. From the interview schedule, informants reported that *"we know what to do in an emergency, but we have no training on emergency procedures"* this statement alluded to the next item that asked teachers whether they have training on emergency or not and the finding reported 89% inadequate. There were also lack of training on evacuation procedures as was reported at 90%. Qualitative data revealed that during an emergency, parents are called to pick their children and teachers do not know what to do next. A representative statement *"during emergency, we call parents to come pick their kids and we do not know what to do next"* on the item accessibility of first aids, this was way inadequate at 90%. From the interview schedule, it was reported that many centres do not have these kits. a representative statement *" we know we are supposed to have these kits, but sometimes when they get finished, we do not have money to buy them"*

V. Discussion

From the ongoing findings, it revealed that almost all teachers indicate lack of written policy on what to do when the child is sick. Almost all teachers also indicated lack of written rules concerning exclusion for contagious illness. Records of immunization were available but only ticked without much explanation on when it was done. The study also revealed that staff were not aware of physical examination and TB test as a requirement for being a teacher. They only know that once they train and have a certificate on ECD that was all. Teachers indicated lack of policy on reporting a child who has been abused or neglected and do have policy on physical or mental health. There was no specific area set aside for a sick child. There were no children allergies and medication schedule posted for staff use and majority of teachers indicated lack of adequate safety and emergency procedures training. Specific emergency evacuation procedures were inadequate with almost all teachers indicating that first aid kits were not accessible.

VI. Conclusion

From the findings, it is evident that many aspects on inclusion of health and safety are inadequate in early childhood education centres. The study concluded that many ECDE Centres in the County lack nurturing care in terms of health and safety. The study revealed that most of components on health and safety included in the early childhood education at preschool centers are at the level of inadequate. Teachers indicated that they know what to do in cases of emergency but lack written policy guiding their actions. This reveals the level of unpreparedness on the part of teachers concerning non- medical arrangements at school level.

VII. Recommendations

- There is need for enabling policies, supportive services, empowered communities and caregivers' capacity building including preschool teachers.
- There is need for availability of developed programmes on stimulation, nurturance and pedagogy of care.
- There is Actions the health system can take to respond to nonmedical concerns of young children that impact their health. This will involve capacity building on health matters.

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