



A Needs
Assessment
Report of
Children 0 – 5
Years

Committee on Promoting Holistic
Development of Preschool Children

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Background

Recent scientific studies have confirmed that early childhood years are an important foundation period in the development of an individual. The family, the community and the government all have important roles to play in promoting the optimal development of children.

In Hong Kong, services for young children are provided by the social service, education and health sectors which may target different needs of children and their families. Each year, over 90% of all newborn babies in Hong Kong receive services from the Department of Health's Maternal and Child Health Centres, which aim to address the needs of young children and their families. Taking these into consideration, a consensus was reached among the Education and Manpower Bureau, the Health, Welfare and Food Bureau, and its departments (viz. Department of Health and Social Welfare Department) that the Department of Health would be in the best position to coordinate joint efforts from the health, social service and education sectors for the implementation of comprehensive and cost-effective policies and services to promote the optimal development of preschool children.

In December 2002, the Director of Health convened the first meeting of the Committee on Promoting the Holistic Development of Preschool Children, which was entrusted with the task of facilitating concerted efforts from all parties, to promote the optimal development of children in Hong Kong. Committee members include representatives from the Education and Manpower Bureau, Social Welfare Department, Department of Health, non-governmental organizations, academic institutions and parents.

In the first Committee meeting, members unanimously agreed that the first step towards promoting the holistic development of preschool children was to identify the needs of children and their families. The Committee decided that a needs assessment of preschool children and their families should be conducted.

With enthusiastic support of the Committee members, professionals from the health, education and social service sectors, academics and parents, the needs assessment of the preschool children and their families is now completed. It is hoped that this report would be a useful reference for service planning and policy making.

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Executive Summary

Introduction

The preschool years have been receiving increasing attention world-wide. The argument for the importance of the early years is mainly based on research in bio-medical sciences including neuroscience, epidemiology, developmental psychology, and developmental psychopathology. While there is little evidence that enriched stimulation beyond the normal range of everyday experience can lead to “advanced” brain development, the research evidence highlights the importance of:

- early childhood experiences and the need to promote the optimal development of children through protection and provision of children’s needs as well as caring and loving relationships;
- the role of the parents or caregivers in promoting the optimal development of children;
- continuous nurturing and trusting relationships beyond the early years and opportunities for life-long learning to foster continuous optimal development; and
- early intervention programmes for children at risk of behaviour, emotional or developmental problems, to address their plight and change the unfavourable trajectory.

Methodology

In this study, both quantitative and qualitative data were collected to obtain information on the current well-being of preschool children, current services and effective programmes to promote their well-being. The quantitative data sources used in the present report included routine data and study reports. The qualitative data sources included documentary review and focus group discussions with various stakeholders.

Current well-being of Hong Kong preschool children and their families

In areas such as infant mortality, under 5 mortality, and immunization rate, Hong Kong is among the best in the world. The data on motor, cognitive, language and moral development, as well as preschool attendance, also suggest that Hong Kong children are comparable to their peers in western societies.

There are concerns about obesity, unbalanced dietary intake, and low physical activity level in Hong Kong children. The breastfeeding rate in Hong Kong is still low compared to other industrialized countries. Child abuse has been a longstanding

problem which needs to be addressed. There is also room for improvement in terms of childhood injuries, child behaviour problems and oral health. Furthermore, stakeholders are concerned about the lack of social skills among preschool children. Stakeholders maintain that more attention should be given to spirituality though there is no consensus on the definition of spirituality. Stakeholders note that there is a long process in the assessment and diagnosis of children with developmental problems.

Both the quantitative and qualitative information indicate that parents are experiencing considerable stress. The major parenting issues raised by stakeholders are high parental expectations, emphasis on academic performance and over-protection, though it is recognized that there are parents who are giving their children minimal attention. There is a concern that parents could only spend very little time with their children. Postnatal depression is another issue of concern.

A few categories of families have been identified as experiencing more problems in parenting. These are parents from low socio-economic backgrounds, lone parent families, and new immigrant families. Stakeholders are concerned that the parenting difficulties in these families are affecting their children's development.

It is pointed out by stakeholders that health indicators need to be developed to systematically and regularly monitor the health of children in the physical, cognitive, social emotional and spiritual domains. This will also provide information for service planning and provision.

Current services

There are programmes catering for the physical, cognitive and social emotional development of children from the health, education and social service sectors. There are also programmes for families and parents. Stakeholders point out that for early childhood provision, there are three government departments focusing on different aspects, and the education of children aged 3 to 6 is left in the hands of the non-governmental and private sectors. Referral within or across sectors is reported to be complicated; children and their parents are often caught in between as a result. Stakeholders from all sectors are calling for more government leadership in preschool education and support for parenting education as well as better co-ordination and collaboration within and across sectors. The issues of registration and training for child minder have also been raised by stakeholders.

Effectiveness of current programmes

In Hong Kong, programme evaluation and quality management activities are still relatively limited, and most of the evaluation activities are based on client satisfaction surveys at the end of the programme. Locally, some parenting programmes have been shown to be effective.

For overseas programmes, there are a fair number of parenting programmes, child behaviour intervention programmes, educational intervention programmes (directed towards parents and/or children), child abuse prevention programmes, breastfeeding promotion programmes, oral health programmes and postnatal depression intervention programmes which have been shown to be effective, including centre-based programmes and home visit programmes. For nutrition, obesity, injury prevention and spirituality programmes, the results are mixed.

Limitations of the present study

The limitations are related to the scope and the methodology of the study. In terms of scope, first, the present study focuses on children 0 to 5 and their families, and the needs of school age children/adolescents have not been examined. Second, this study examines the well-being of the general population of children 0 to 5 and detailed information on special needs groups has not been included. Third, the information collected is based mainly on a review of routine data/official statistics and study reports. No field studies have been conducted. Fourth, the present study is based on a search of literature in the health and social science fields. No policy analysis is involved. For methodology issues, the official statistics referred to in this report is a reflection of supply (what is actually provided), rather than need. Second, study reports which are not abstracted in the databases or uploaded on the internet might not be known to the researchers. Third, there is the issue of publication bias for literature on the evaluation of programme effectiveness. Fourth, there is very limited information on the economic evaluation of local and overseas programmes. Fifth, while the qualitative data provides information about the issues of concern among the participating stakeholders, the data cannot tell us the extent or prevalence of the problem and we cannot claim that the sample is a representative one. The qualitative information is supplementary and complementary to the quantitative information.

Recommendations

Principles and strategies of intervention

Before discussing the recommendations, it is important to outline the principles and strategies of intervention. First, it is recognized that prevention is a potentially more cost-effective strategy to reduce the impact of child health problems on the individual and the community. Second, in promoting child health and well-being, multiple health determinants should be targeted. Third, to address the multiple determinants and to empower the individual to take control of his or her own behaviour and environment, multifaceted health promotion strategies including building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services are necessary. Fourth, to target the multiple determinants in a co-ordinated way, multi-sectoral collaboration and the establishment of a central co-ordinating body are important. Fifth, settings for health offer practical opportunities for the implementation of health programmes. Finally, services and programmes should be evidence-based.

There are two categories of recommendations: recommendations that involve mainly service providers and professionals at the operational level, and recommendations requiring the leadership and commitment from high ranking government officials and policy makers.

Operational level recommendations

- **Child behaviour problems and parenting difficulties**
 - Parenting education should continue to be promoted and developed. Both universal and indicated programmes (targeted at parents with children with behaviour problems or parents with parenting difficulties) should be promoted and developed. New parents and parents-to-be should be encouraged to attend parenting programmes.
 - Preschools (including parent-teacher associations), and Maternal and Child Health Centres (MCHCs) (including ante-natal classes) should continue to be used as venues for delivering parenting education.
 - There is a need to train parent leaders to have the knowledge and skills to work for parent-teacher associations.
 - The option of preschool-based child behaviour intervention programmes should be explored.
 - The behaviour management skills component should be strengthened in training courses for preschool teachers.
 - Development of valid local instruments to measure child social behaviour

and local norms for parenting issues should be explored.

▪ **Breastfeeding**

- A high level multi-sectoral breastfeeding committee with representatives from relevant government departments, non-governmental organizations (NGOs), and health professional associations should be established.
- More support for sustaining breastfeeding through staff, volunteers and hotline should be explored. Home visits should be considered.
- The possibility of re-cycling and lease of breastfeeding equipments for needy families could be explored.
- There should be more publicity on available breastfeeding resources.
- There should be more public education about breastfeeding.
- Availability of suitable places for breastfeeding in public venues and workplaces should be promoted.

▪ **Oral health**

- The Department of Health (DH) oral health promotion programme being piloted in MCHC, if found to be effective, should be extended to all MCHCs.
- The DH oral health promotion programme in preschools should be further promoted.

▪ **Postnatal depression**

- Research on the effectiveness of treatment and the outcomes of screening in the local context should be conducted.

▪ **Child abuse**

- The issue of child abuse, both in terms of prevention and treatment, should continue to be monitored by the multi-sectoral committee chaired by the Director of Social Welfare.

▪ **Lifestyle issues**

- More comprehensive information on diet and physical activities should be collected.
- There should be safe outdoor and indoor play facilities for children, such as playground and game room.
- Effective programmes to promote healthy eating behaviour and regular physical exercise should be developed. These should include guidance to parents/caregivers and the preschool setting is an appropriate setting for health promotion.

▪ **Childhood injuries**

- There should be further development and evaluation of home injury prevention programmes in the local context.

- **Spirituality**
 - A working group should be set up to come to a working definition of spirituality.
- **Inter-disciplinary and inter-sectoral collaboration**
 - A good entry point for service integration for children 0 to 3 is the MCHC. The existing services can be enriched by integration with services provided by Social Welfare Department (SWD) and NGOs. A new model for integrated services can be explored and developed. There should be inbuilt evaluation mechanisms to evaluate the effectiveness of the model.
 - For children aged 3 to 5, it is recommended that a pilot health promoting preschool programme should be set up. Evaluation mechanisms should be built into the pilot project.
- **Establishment of a set of health indicators**
 - To search for or develop suitable and valid local indicators in the cognitive domain, child social/behavioural domain, spiritual domain (after consensus on its definition is achieved) and parenting issues.
- **Programme evaluation**
 - There should be rigorous research to establish the effectiveness of local programmes before their launching.
 - There should be evaluation of ongoing programmes and quality management measures instituted, as necessary, to ensure that the objectives of the programmes are met.
 - Training on research methods and programme evaluation should form part of professional training and in-service professional development.
 - The DH Positive Parenting Programme (Triple P) database and parent education database could serve as an interim platform to support the evaluation of parenting education programmes.
- **Needs assessment on special groups**
 - Needs assessment be conducted for preschool children from lone parent families, new immigrant families, ethnic minority families, families where the mothers are in mainland China, and families with socio-economic disadvantages.
 - Needs assessment be conducted for preschool children with developmental problems.

Policy level recommendations

- **Government policy and co-ordination**
 - The creation of a family-friendly environment to support parents in performing their parenting roles more effectively is important to the healthy development of preschool children. Family-friendly policies to support child and family well-being should be considered.
 - The Government should consider taking the leadership role in various areas of early childhood provision, notably in the areas of early childhood education and quality assurance of child-minders and tutors in the after-school interest classes.
 - Joining up of government bureaux/departments in the formulation and implementation of child and family policies to promote child and family well-being. The establishment of a Children's Commission could be considered.
- **Evidence-based policies**
 - Careful examination of evidence of the likely effectiveness of potential policy actions should be conducted before decisions on policies are made.
 - To inform the development and implementation of policies on child well-being, large scale longitudinal studies addressing the multi-determinants of child development in the local context are needed. Among many others, potential areas could include the impact of parental employment on parent-child relationship, the impact of education experience (e.g. enrichment classes) and mass media on the social, cognitive and cultural development of children.
 - New policy initiatives should be subject to pilot trials and be evaluated against a set of agreed indicators.

Setting priorities

As there are a fair number of recommendations, and some recommendations need to be in place before others can be implemented, it is necessary to set priorities for their implementation to provide direction and to ensure that the implementation is organized and co-ordinated.

At the conceptual level, what is needed is a consensus on what spirituality is. Without a consensus on its definition, development of measurement tools and intervention programmes are not possible.

To ensure that programmes are tailored to the specific needs of different groups of preschool children and their families, needs assessment is a prerequisite for service planning. Further needs assessment for special groups should be conducted to

understand their specific needs. The availability of valid local indicators and measurement tools makes important contributions to needs assessment. Development of these should therefore be considered a priority. On service provision, many of the intervention and education programmes for preschool children and their families are already in place and these should continue to be provided and developed. Nonetheless, rigorous programme evaluation and quality management are extremely important in ensuring that programmes and services offered are effective in meeting the needs of preschool children and their families and are of high standards. All service providers should strive to build evaluation and quality management mechanisms into all programmes. Last but not the least, inter-sectoral collaboration is vital in ensuring that programmes are comprehensive and that gaps, overlaps and inconsistencies across services are minimized.

Above all, government leadership, including the establishment of a central body, is crucial to address the multi-determinants of health through formulating supportive public policies and co-ordinating actions across the government and non-government sectors to provide the favourable environment where families and children flourish. The development and implementation of these policies should also be evidence-based.

Chapter 1

Introduction

This introductory chapter sets the scene for the study. Firstly, the basic principles of child development using a holistic view and an ecological framework are outlined. This is followed by a discussion of contributions from research of different scientific disciplines to the importance of the early years. Then, the obligations of Hong Kong, as one of the signatory parties to the United Nations Convention on the Rights of the Child (UNICEF, 1989), to promote the well-being of children, are underscored.

Basic principles of development

Development is defined as “a systematic, organized, intraindividual change that is clearly associated with age-related progression, and is carried forward in some ways that has implications for a person’s pattern or level of functioning at some later time” (Rutter, 1994, p.4).

In line with modern developmental approach, this study adopts a holistic view emphasizing links across multiple domains of development, i.e. physical, cognitive, social emotional and spiritual (O’Donnell, 1986). Developmental tasks or issues are conceptualised as being broadly integrative, cutting across the physical, cognitive, social emotional and spiritual domains and issues or tasks at one stage lay the groundwork for subsequent tasks or issues (Sroufe & Rutter, 1984). The timing and rate of developmental processes, however, vary greatly across different domains.

In this study, development is viewed from an ecological framework (Bronfenbrenner, 1979, 1989; Buchanan, 2000), which sees a child’s development as being shaped by the interaction of both nature and nurture, including the child’s biogenetic makeup, his/her experiences and interactions with others in the family, and the social environment. Though most researchers nowadays agree that it is the interaction between nature and nurture that should be considered, it is also thought that the relative influence of the two may vary depending on the different aspects of development (Bee, 2000). For example, physical development is strongly influenced by nature and given the minimum necessary environment, maturation will occur. Cognitive development lies in the middle of the continuum. While internal forces are clearly at work, it is well known that a host of environmental factors can influence cognitive development. Social emotional development is at the other end of the continuum where environmental forces are influential but genetic factors are still operational.

Concerning the interaction between the individual and the environment, five major principles are postulated (Bee, 2000; Rutter et al., 1997). First, there are individual differences in reactivity to the environment. Different children react differently to the environment, some being more sensitive to changes, while others are less reactive. The differences in reactivity may be due to temperamental differences or cumulative past experiences. Second, there is a two-way interplay between children and their environment. The influence is two-way, rather than one-way. For example, children with inborn difficulties in reading may read less because of their difficulties. However, reading less results in these children having less experience conducive to the development of reading skills. Third, an ecological framework should be adopted. As mentioned above, events occur within the context of the family and the larger community and these contextual factors play a part in determining the impact of events on children. Fourth, the subjective meaning of experiences is important. It is children's understanding of the meaning of their experiences that governs the effect of the experience, not just the experience itself. In other words, the same experience might have different effects on different children, depending on their different interpretations of the event. Finally, children are not just passive recipients of environmental forces. Children act on the environment as they choose their behaviours and their associates which might in turn influence their behaviours and experiences. In this sense, children shape and select their own environment.

It is also important to adopt a lifespan perspective as development and changes occur throughout the whole lifespan (Rutter & Hay, 1994). Throughout development, experiences are programmed into the biological and behavioural systems' structure and functioning. Developmental outcomes are influenced by multiple determinants including the environmental, social, psychological and biological systems and there are risk and protective factors. Many of the early life experiences are related to developmental outcomes later in life and changes in functional status (e.g. physical functioning, cognitive functioning, social emotional functioning) over time are conceptualized in terms of trajectories of development (Halfon & Hochstein, 2002).

Developmental psychologists have also mapped out the major developmental tasks during the preschool period (Sroufe, 1979; Bee, 2000). These include: (1) physiological regulation, harmonious dyadic interaction and establishment of an effective attachment relationship and basic trust during infancy; (2) exploration, experimentation, and mastery of the environment (with the caregiver as a secure base), individuation and autonomous functioning, and impulse control during toddlerhood; and (3) self-control, self-reliance, initiative, sex role identification, establishing

effective peer interactions and developing a sense of empathy in the latter part of this period. Early attachment and bonding with parents serve as a foundation for future relationships, the emergence of self-control and self-regulation as well as cognitive development.

To sum up, in development, both nature and nurture are important influences. However, in all cases, the child plays an active role in selecting and interacting with the environment, making sense of the environment, reacting to the environment, and shaping the environment. A holistic view of development, within an ecological framework, using a lifespan perspective, taking into consideration the child, the environment, and their interactions, as well as the impact of early experience on later development is needed in understanding the complexities of development. The above issues in child development are summed up in the diagram below:

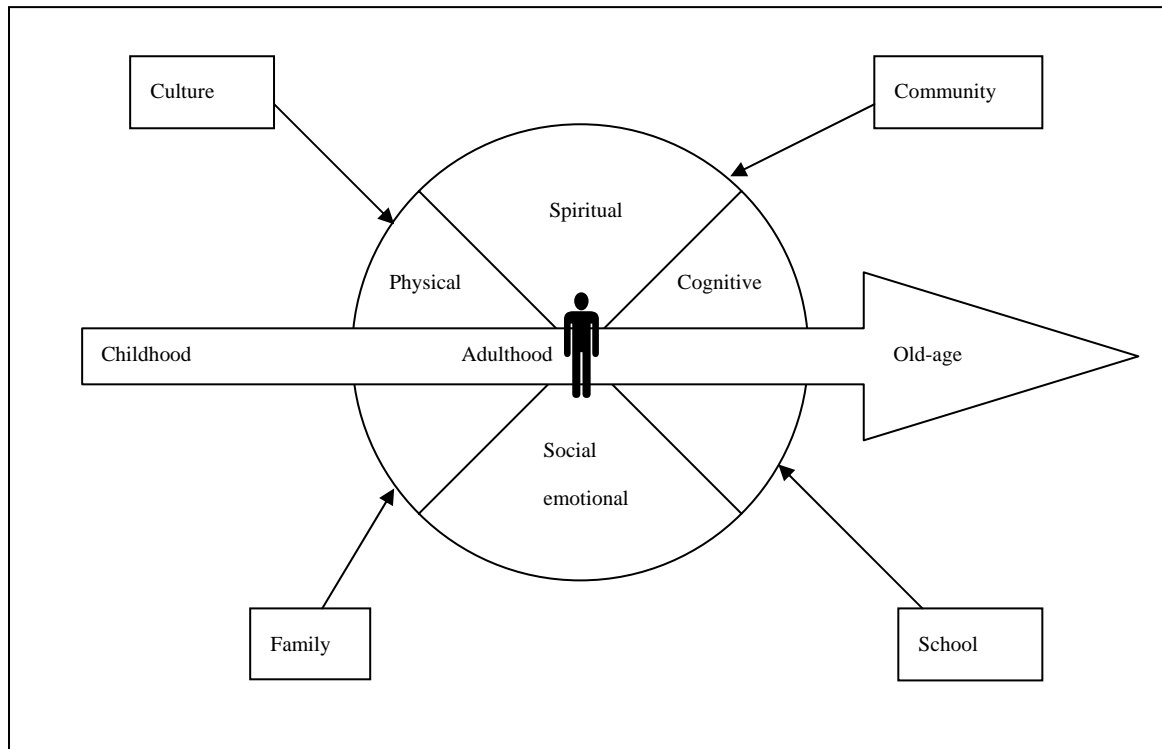


Figure 1. Diagrammatic representation of issues in child development (based on Hancock, 1985).

Importance of the early years

The preschool years have been receiving increasing attention and many have argued that the early years lay the foundation for future development in all areas (McCain & Mustard, 1999). The argument is based mainly on research in bio-medical sciences including neuroscience, epidemiology, developmental psychology, and developmental psychopathology.

There is clear evidence that genetic factors play an important role in accounting

for individual differences (Rutter et al., 1997; Rutter, 2002). For example, Down syndrome, a form of chromosomal anomaly, is one of the most frequent genetic causes of intellectual disability (Rende & Plomin, 1994; Bee, 2000). Apart from genetic factors, environmental insults during the intrauterine life, especially the first trimester of pregnancy, can also cause damage to the developing brain. One form of environmental insult is diseases in the mother which can affect the embryo or foetus. An example is rubella infection where foetal exposure during the first few weeks of gestation will result in abnormality such as heart defect, deafness and cataract (Banatvala & Brown, 2004). Another form of environmental insult is neuro-toxins such as tobacco, alcohol, lead etc. Smoking in mothers is related to low birth weight in infants (Bernstein & Divon, 1997). Heavy drinking in mothers is associated with foetal alcohol syndrome (FAS) in their children. FAS children are often found to have “craniofacial, central nervous system, skeletal, cardiac, and urogenital abnormalities, along with prenatal and postnatal growth deficiencies” (Swayze et al., 1997, p. 232). Intellectual disability is often found to be associated with FAS (Swayze et al., 1997). Longitudinal studies have also shown an association between elevated blood lead level in newborn infants and lower intelligence scores in childhood (e.g., Streissguth, Barr, & Sampson, 1990). A third form of environmental insult is related to nutrient deficiency. Diet deprivation during pregnancy appears to have great impact on development during foetal growth. Energy and protein deficiency and inadequate maternal intake of micronutrients are associated with intrauterine growth retardation and adverse foetal growth (Kramer, 2002; Fall et al., 2003; Merialdi et al., 2003). Prenatal malnutrition also has adverse effects on cognitive and psychosocial development (Smedler, Faxelius, Bremme, & Lagerstrom, 1992; Almeida, Tonkiss, & Galler, 1996).

The concept of biological programming is also used to explain the relationship between birth weight and various aspects of adult health (Blair, Steward-Brown, Waterston, & Crowther, 2003). This concept can be illustrated by the foetal origins hypothesis, which states that foetal under-nutrition in middle to late gestation leads to disproportionate foetal growth, which programmes later adult disease (Barker, 1995; Lucas, Fewtrell, & Cole, 1999). Examples of adult diseases include abnormal blood lipid values, diabetes, hypertension, and coronary heart disease (Lucas et al., 1999). Barker (1994) postulates that the baby adapts to under-nutrition by hormonal changes, which, “together with changes in the structure of organs, and the types and number of cells within them, may permanently programme the body’s metabolism” (p. 135). However, the specific mechanisms or factors explaining this relationship are still to be identified.

In developmental psychology, the importance of the early years is based on the conceptualization of the child as a coherent person and individual development is thought to be a coherent process (Sroufe, 1979). Early experiences will have an impact on later development, and adult adjustment is often predictable from childhood behaviour (Rutter, 2002b). There are direct and indirect chain effects and one set of early advantage may lead to further advantages and early disadvantages may lead to further disadvantages (Rutter, 1994). The impact of early experiences may also be subtle or complex, resulting in the individual being more vulnerable or resilient to various forms of stress (Bee, 2000). This highlights the importance of provision of positive and successful early experiences for children to promote their well-being. In this respect, parents or major caregivers are the primary socializing agents of the child. The child's intellectual development, future attitudes, values, habits, health behaviour, lifestyles and coping styles are all primarily influenced by parents since early life.

Developmental psychopathology research has also pointed to the important influence of the early years on later psychological adjustment. It is found that adolescent conduct problems, delinquency and substance abuse are linked to conduct problems at an early age (Patterson, Forgatch, Yoerger, & Stoolmiller, 1998; Barkley, Fischer, Edelbrock, & Smallish, 1991; Earls, 1994; Loeber & Hay, 1994; Campbell, 1995; Webster-Stratton & Hancock, 1998). Children who are impulsive or hyperactive can sometimes be overwhelming for parents and many parents may respond with harsh and inconsistent discipline. These disciplinary techniques are likely to lead to more conduct problems in children (Webster-Stratton & Taylor, 2001). This leads to a vicious cycle where ineffective parenting leads to child behaviour problems which lead to increased difficulties in parenting. Children with behaviour problems face a greater chance of being rejected by teachers and peers in school. Rejected children often make friends with other rejected children and reinforce each other's antisocial behaviour. Early childhood conduct problems "may result in a synergistic cycle of cumulative events that increasingly compromise children's functioning over time" (Webster-Stratton & Taylor, 2001, p. 166). One of the effective interventions is early intervention programmes for parents of preschool children to equip them with skills and knowledge to promote appropriate behaviours in their children, before the development of peer rejection and school problems due to aggressive behaviours (Webster-Stratton & Hancock, 1998).

Neuroscience research has shown that the early years of life in children is an important period in brain development as it is a period of "rapid synapse formation that connects nerve cells into functioning circuit" (Bruer, 1999, p.12). During this period, synapses are over-produced and proper connections are retained while the

extras are lost (Greenough, Black, & Wallace, 1987).

In animals which were visually deprived briefly during the postnatal sensitive period, their nerve cells made fewer interconnections than animals not visually deprived and there were visual impairments among the former group. Animals reared in complex environments learned better than animals reared in bare environments and the former group had more synapse connections than the latter group (Greenough et al., 1987).

Based on these findings, proponents argue that the early years are important because synapses that are not used will not be retained (Mc Cain & Mustard, 1999). It is proposed that enriched environments and increased stimulation can have the greatest impact on brain development during this period of rapid synapse formation (McCain & Mustard, 1999; Guy, 1997; Bruer, 1999). Adult interaction with the child during this period is regarded as the key to brain development. A secure attachment relationship with an adult, with care and stimulation, will establish the wiring patterns in the brain which will influence future learning and social adjustment (Hawley, 1998; Guy, 1997). In addition, early intervention programmes for high risk children are vital for their development. Early intervention projects such as the Abecedarian Project has been found to be effective in promoting cognitive development and academic achievement (Ramey et al., 2000).

While the importance of early attachment to later adjustment and the importance of early intervention programmes for children from disadvantaged backgrounds are well recognized (Schweinhart & Weikart, 1990; Ramey et al., 2000; Rutter, 2002a), others, however, caution against possible misleading extrapolations of the neuroscience findings (Bruer, 1999; Rutter, 2002a). It is pointed out that brain development is far from over by the age of three years and important changes and development continue to occur through adolescence (Rutter, 2002a). Learning later in life can also impact on brain size in areas of the brain required for those tasks (Reid & Belsky, 2002) and brain development is ongoing with lifelong learning. Two types of processes are distinguished (Greenough et al., 1987; Rutter, 2002a). Experience-expectant process is regarded as “a neural preparation for incorporating specific information” (Greenough et al., 1987, p. 539) during a restricted period. An excess number of synapses are produced but only a subset will be preserved by neural activity generated by experience. This is related to early age-locked sensory system development described earlier (Greenough et al., 1987). Experience-dependent process is a dynamic synapse formation process where individual unique experiences have neural effects and this continues throughout life (Greenough et al., 1987; Rutter, 2002a). Both processes are at work and though early experiences are important, it is wrong to assume that later experiences have only minor influences (Rutter, 2002a).

Others also argue that for experience-expectant processes, in normal circumstances, most babies will get adequate experiences to retain the synapses needed. The “bare environments” in animal studies are extreme and severe deprivations which are very rare in human societies. Studies on children exposed to severe early deprivation show that “significant catch-up, but not complete recovery, is possible even after prolonged exposure to deprivation” (O’Connor et al., 2000). Moreover, it is not clear whether retaining more synapses is actually beneficial and there is no clear evidence that enriched stimulation beyond the normal range of everyday experience can foster brain development (Bruer, 1999; Hannon, 2003). Further research in these areas is needed but the existing data do confirm the importance of early intervention programmes for children from deprived backgrounds in improving their life outcomes and the importance of adequate stimulation and secure attachment relationship for all children.

To sum up, researches in bio-medical sciences including neuroscience, epidemiology, developmental psychology, and developmental psychopathology highlight the importance of early childhood experiences and the need to promote optimal development of children. This should be achieved through protecting the child from harm and providing all the child needs for optimal growth and development, which include not only bodily needs but more importantly, caring and loving relationships. The parents or caregivers, as the primary socializing agents for children, play an important role. Continuous nurturing and trusting relationships beyond the early years and opportunities for life-long learning are also needed for continuous optimal development of the person. Early intervention programmes for children at risk of behaviour, emotional or developmental problems are required to address their plight and change the unfavourable trajectory. However, there is little evidence that enriched stimulation beyond the normal range of everyday experience can lead to “advanced” brain development.

The United Nations Convention on the Rights of the Child (UNICEF, 1989)

The United Nations Convention on the Rights of the Child (the Convention) was adopted by the United Nations General Assembly in 1989. The Convention is an international treaty that recognizes the human rights of children, defined as persons up to the age of 18 years. It provides a universal set of standards to be adhered to by all countries. It spells out the basic human rights for all children, everywhere, all the time: the right to survival; to develop to the fullest; to protection from harmful influences and abuse; and to participate fully in family, cultural and social life. The Convention was ratified by the United Kingdom and China in 1991 and 1992

respectively. Service planning and delivery should be guided by the principles and values incorporated in the Convention. For Hong Kong to fulfil its obligations under the Convention, review of the current well-being of children and current programmes for children, identification of effective interventions and drawing attention to related policy and service implications are some of the essential measures. As a start, this study focuses on preschool children and their families.

Summary and conclusion

To sum up, a holistic view of development, emphasizing links across the physical, cognitive, social emotional and spiritual domains, is adopted. Health and development are products of the interaction of nature (biogenetic makeup) and nurture (environmental influences), with the latter being more amenable to change. It is also recognized that early experiences not only impact on the child's health and development, but also adult health.

To promote the holistic development of preschool children and to safeguard their human rights, it is important that an enabling home and social environment be provided for all children, and that effective programmes are available for those in need. To ensure that the current services and programmes are relevant and effective, it is necessary to conduct regular needs assessments to review the current states of well-being of preschool children, and the extent to which their needs are satisfied.

In chapter 2, the methodology employed in the present needs assessment is described. Chapters 3 and 4 outline the current situation of preschool children and their families and the current services and programmes. Chapter 5 reviews the effectiveness of local and overseas programmes in meeting the needs of preschool children and their families. In chapter 6, the limitations of the present needs assessment study are described. Finally, chapter 7 outlines the recommendations about future directions.

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Chapter 2

Major Research Questions and Methodology

Health needs assessment

Bradshaw (1972), in his taxonomy of social needs, distinguishes between normative needs (need defined by the professional), felt needs (what people consider they want), expressed needs (felt need expressed by an action) and comparative needs (comparing two populations receiving different service levels). This taxonomy is commonly used in the social and education fields but its application in the public health setting may sometimes be inappropriate as in the latter, increasing input of care could be associated with either benefit or harm (Stevens & Raftery, 1994).

In public health, using an epidemiological approach, health needs assessment “is a systematic method of identifying unmet health and health care needs of a population and making changes to meet these unmet needs” (Wright, 2001, p.38). Need implies “the capacity to benefit from an intervention” (p.39). Need should be distinguished from demand and supply. While need refers to what people might benefit from, demand is what people are willing to pay for in a market or might use in a free health care system. Supply, on the other hand, refers to the actual provision. In real life situations, need, demand and supply may overlap or differ, and work is often required to make supply, demand and need more congruent (Stevens & Raftery, 1994).

In addition to the epidemiological approach to needs assessment, it is also important to incorporate other approaches, namely, comparative needs assessment and corporate needs assessment (Stevens & Raftery, 1994). The former refers to comparison with available services to similar populations in other areas. The latter refers to obtaining the views of various stakeholders with a range of perspectives and experiences.

In this study, we adopted predominantly the epidemiological approach to health needs assessment which involves three components: measuring incidence or prevalence of the problem of the target population, assessment of the effectiveness of interventions and availability of effective interventions for the problem, and obtaining information on the services currently provided. Decisions are made in consideration of the ability of the population to benefit from the intervention. In addition, we integrated the corporate approach, by conducting focus group discussions with service providers and service users to obtain their views and perspectives, as well as the comparative approach, through comparison with overseas situations where appropriate.

Major research questions

Based on the above, there were three major research questions to be answered in this study. The first question was how well Hong Kong preschool children and their families were doing in various domains, viz, physical, cognitive, social emotional and spiritual. The second question related to the availability of current services. The third question was about the effectiveness of existing programmes and availability of effective programmes to address a particular problem. To answer these questions, information was collected through literature search, service and official statistics and focus group discussions with stakeholders.

As mentioned in chapter 1, families play a vital role in the development of preschool children. Therefore, in the health needs assessment of preschool children, it is important to include the family in the assessment. It is also recognized that many health problems that are manifested in older children and adolescents may have their roots in the preschool years, e.g. obesity and delinquency. Adolescent statistics may reflect the health needs of preschool children. In the present health needs assessment of preschool children, information on adolescents and older children would be used, where appropriate. In this report, preschool children refer to children aged 0 to 5 years old.

Sources of data

There are many different sources of data on the needs of preschool children and their families. Different types of data differ in their completeness, accuracy, relevance/representativeness and timeliness (Tennison, 2001). Bearing in mind that the quality of the information may differ, this report made use of various data sources in order to build a comprehensive picture on the health needs of preschool children and their families. Where possible, the limitations of the data were stated, to alert the reader to cautions in interpretation.

In this study, both quantitative and qualitative data were used. The data sources used in the present report included:

1. Quantitative data

1.1 Routine data source

- Census information – this was based mainly on the 2001 census conducted by the Census and Statistics Department.
- Routine health data – this included information on mortality etc. collected by the Statistics Section of the Department of Health (DH).
- Service data – this included data from Social Welfare Department (SWD), Education and Manpower Bureau (EMB), Hospital Authority (HA) and DH (Family

Health Service and Child Assessment Service). The data was mainly based on service utilization and might not capture those who were not utilizing services.

1.2 Surveys and study reports

- Surveys reports/study reports – these included surveys and reports (published and unpublished) on specific topics produced by various government departments and non-governmental organizations (NGOs). The quality varied depending on the research methodology.
- Research reports published in refereed academic journals – this included research on specific issues and the focus might be on answering specific research questions.
- Systematic reviews – this was mainly relevant to the section on the effectiveness of services. Systematic reviews on effective programmes were referred to where appropriate. Most of them were on overseas programmes.

2. Qualitative data

2.1 Documentary review

Information on service provision by various government departments and NGOs, including information on the internet, were accessed.

2.2 Focus group discussions

Focus group discussions were held with stakeholders to collect their views on the health needs of preschool children and their families. The purpose was to capture the major variations and common themes across sectors, rather than making generalizations (Patton, 1990). The sampling method adopted was the stratified purposeful sampling method and a series of focus group discussions with stakeholders such as parents, preschool workers (day nursery workers, crèche workers and kindergarten teachers), social workers, academics from training institutes for preschool workers, and health professionals, were conducted to find out their views and perceptions on the needs of preschool children and their families.

Data collection

Data was collected via three different methods:

3. Information supplied by organizations

An invitation letter was sent to NGOs via the Hong Kong Council of Social Service to request them to supply information on services and programmes for preschool children and their families. Relevant government departments were requested to supply information on services and programmes for preschool children

and their families. These government departments and NGOs were also requested to supply information on any evaluation reports of their services and programmes. Search of websites of various NGOs which had not responded to the Hong Kong Council of Social Service were also conducted to access additional information.

4. Literature search

This included search on official statistics, refereed journal articles and various surveys reports and study reports (published or unpublished) produced by government departments and NGOs. The search engines used included Medline, PubMed, Cochrane Database of Systematic Reviews, and PsycINFO.

5. Focus group discussions

Sixteen focus group discussions (141 participants) were conducted. A focus group discussion guide was used to guide the discussion. The discussion guide is in Appendix 1. Unless otherwise specified, the focus group discussions were conducted in Cantonese. The discussions were tape recorded and transcribed verbatim. In the main text of this report, the English translation (slightly edited) would be presented (original English words would be underlined) and the original Chinese version can be found in Appendix 2. The details of the focus groups are listed below:

- Day nursery workers – there were 16 participants recruited through the Hong Kong Council of Social Service. The participants included 5 principals/supervisors (園長/副園長/主任) and 11 teachers from subvented day nurseries.
- Crèche workers – there were 6 participants recruited through the Hong Kong Council of Social Service.
- Kindergarten workers – there were 16 participants recruited through the EMB. The participants included 11 principals/supervisors (校長/主任) and 5 teachers from various kindergartens.
- Family support service supervisors – there were 5 participants who were supervisors/directors of various family support services. They were recruited through the Hong Kong Council of Social Service.
- Child care service supervisors – there were 7 participants who were supervisors of child care services. Again, they were recruited through the Hong Kong Council of Social Service.
- Academics – there were 14 academics from the four academic institutions offering recognized professional training to preschool workers (see Appendix 3). The discussion was conducted in English as one of the participants was not fluent in Chinese.
- Paediatricians in hospitals – an invitation letter was sent to the 17 Chiefs of

Service of paediatric departments in all hospitals and the Consultant, Child Assessment Service (CAS), DH. Representatives from 13 paediatric departments and CAS participated in the focus group discussion.

- Paediatricians in private practice – invitations to paediatricians in private practice were sent through their continuous medical education network. A total of 10 paediatricians volunteered to participate in the focus group discussion.
- DH health professionals – three focus groups were conducted, one for doctors from Family Health Service (FHS) and CAS, and two for nurses from FHS and CAS. Altogether, 24 nurses (14 registered nurses and 10 nursing officers) and 9 doctors participated.
- Parents of preschool children – five focus groups were conducted, two recruited through a parents' self-help group, and three recruited through Maternal and Child Health Centres (MCHCs). A total of 21 parents participated in the discussions.

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Chapter 3

Well-being of Hong Kong Preschool Children and Their Families

According to the World Health Organization (WHO), health is “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (WHO, 1948, p. 100). Apart from physical, social and mental aspects, the concept may be broadened and optimal health can be defined as “balance of physical, emotional, spiritual, intellectual and social health” (O’Donnell, 1989, p. 5). The WHO also identifies several priority areas for future action for promoting child and adolescent health and development (WHO, 2003). The areas include health of mothers and neonates, prevention of communicable disease, prevention of injury (from violence and the physical environment), good nutrition, psychosocial development and mental health.

As mentioned in chapter 2, the well-being of preschool children is closely related to the well-being of their families. In this chapter, information on the well-being of preschool children and their families is presented.

Child profile

1. General information

1.1 Census information

In the 2001 Hong Kong census (Census and Statistics Department, 2002a), there were 355 197 children aged 0 to 5 living in Hong Kong, representing 5.3% of the total population. There were 184 905 boys (52.05%) and 170 292 girls (47.95%).

1.2 Infant mortality rate

Infant mortality rate is regarded as a useful indicator of a community’s level of health (Beaglehole, Bonita, & Kjellstrom, 1993; Last, 2001). It is associated with factors such as access to medical care, socio-economic conditions, and public health services (Federal Interagency Forum on Child and Family Statistics, 2003). In Hong Kong, there is a steady decrease in infant mortality rate since 1961. In 2002, the infant mortality rate in Hong Kong was 2.4 (Department of Health, 2004), ranking among the best in the world (Australia: 6; Denmark: 4; Finland: 4; Iceland: 3; Sweden: 3; U.K.: 6; U.S.A.: 7) (Federal Interagency Forum on Child and Family Statistics, 2003; UNICEF, 2003). The relevant vital statistics are shown in Table 1. The leading causes of infant mortality were congenital anomalies, disorders relating to short gestation or unspecified low birth weight and respiratory distress syndrome and other perinatal disorders (Department of Health, 2002a).

Table 1

Vital Statistics in Hong Kong, 1961-2002 (Department of Health, 2002a, 2004)

Year	Crude birth rate ^a	Crude death rate ^b	Perinatal mortality ^c	Neonatal mortality ^d	Infant mortality ^e	Maternal mortality ^f
1961	34.3	5.9	26.3	21.0	37.7	46.0
1971	19.0	5.0	17.7	12.6	18.4	14.3
1981	16.8	4.8	10.8	6.6	9.7	8.0
1991	12.2	5.0	6.4	4.0	6.5	5.7
1995	11.1	5.0	5.6	2.5	4.4	7.3
1999	7.6	5.1	5.7	1.6	3.2	2.0
2000	8.1	5.1	6.8	1.7	2.9	5.6
2001	7.3	5.0	5.7	1.7	2.7	2.0
2002	7.1	5.1	7.4	1.3	2.4	2.1

^a Number of births per 1 000 population

^b Number of deaths per 1 000 population

^c Number of still births and early neonatal deaths (< 7 days) per 1 000 total births (number of still births and number of registered live births)

^d Number of deaths in infants under 28 days of age per 1 000 registered live births

^e Number of deaths in children less than one year old per 1 000 registered/known live births

^f Number of registered maternal deaths (death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes) per 100 000 registered live births

1.3 Under-five mortality

Under-five mortality is also regarded as an important indicator of the health in the community (Federal Interagency Forum on Child and Family Statistics, 2003). In Hong Kong, the under-five mortality rate in 2001 was 0.7 per 1 000 population aged under 5 or 3.8 per 1 000 registered live births (Department of Health, 2002a). The 2001 under-five mortality rate in industrialized countries was 7 per 1 000 live births (UNICEF, 2003). The Hong Kong rate compares well with that in industrialized countries (Australia: 6; Denmark: 4; Finland: 5; Iceland: 4; Sweden: 3; U.K.: 7; U.S.A.: 8) (UNICEF, 2003).

Congenital anomalies remain the major cause of death for children under one year. Congenital anomalies, injury and poisoning, disease of the nervous system, pneumonia and malignant neoplasms are the major leading causes of deaths for

children aged 5 or below (Department of Health, 2002a).

2. Physical domain

There are a number of issues discussed under the physical domain. These can be grouped into three major categories. The first category is physical growth and development and includes such issues as birth weight, height growth, obesity and motor development. The second category is about the use of preventive health services which includes MCHC coverage and immunization. The third category is childcare/rearing practices and problems arising from them. These include issues like breastfeeding, nutrition, oral health, physical activity, exposure to tobacco smoking, unintentional injury and child abuse. Finally, views from stakeholders are presented.

2.1 Physical growth and development

2.1.1 Birth weight

Over the years 1984 to 1998, the birth statistics system showed that the mean birth weight was stable, ranging from 3.18 kg to 3.21 kg. Male infants were heavier than female infants and the mean weights were 3.24 kg and 3.14 kg respectively (Luk, Yeung, & Lo, 2001).

Low birth weight (less than 2.5 kg) is related to a range of health risks, including higher risks of dying during the early months and years, long-term illness and disability (Federal Interagency Forum on Child and Family Statistics, 2003; Ministry of Health, 1998). The proportion of low birth weight (<2.5 kg) is around 7% for industrialized countries (MacDorman, Minino, Strobino, & Guyer, 2002). In Hong Kong, based on the birth statistics system, the proportions of low birth weight (<2.5 kg) and very low birth weight (<1.5 kg) were 4.99% and 0.56% respectively (Luk et al., 2001). The Hong Kong low birth weight figures are very comparable to those of industrialized countries (Australia: 6.6%; Denmark: 6.0%; Finland: 6.0%; Iceland: 4.0%; Sweden: 4.0%; U.K.: 7.6%; U.S.A.: 7.6%) (UNICEF, 2001).

Based on a 20% random sample of live-born singletons born between 1984 to 1997 from the birth statistics system, it was found that birth weight was positively related to mother's educational attainment. Birth out of marriage and living in temporary housing were predictive of lower birth weight (Cheung & Yip, 2001).

2.1.2 Height growth

A 1993 territory wide survey of about 25 000 Chinese children from birth to 18 years indicated that there were secular changes in standing height and sitting height. Compared to a similar survey in 1963, there was an increase in final adult standing

height among boys (3.6 cm) and girls (2.7 cm), in which 1.8 cm (boys) and 0.5 cm (girls) were accounted for by the sitting height. For boys of 4 and 5 years old, the increases in standing height were 1.7 cm and 2.3 cm respectively. The corresponding figures for girls were 2.3 cm and 3.3 cm (Leung et al., 1996).

2.1.3 Obesity

Obesity in childhood often persists into adulthood as lifestyle habits established early in life are frequently carried into adulthood. It is well known that obesity in adulthood is a risk factor for many chronic conditions including diabetes and hypertension (Kiefer, Lee, & Summer, 2002). An international standard definition for child overweight and obesity was developed out of six large national data sets (Brazil, U.K., Hong Kong, Netherlands, Singapore and U.S.A.). The Hong Kong data set consisted of about 25 000 males and females aged 0 to 18 years (see also section 2.1.2). Based on the centiles corresponding to body mass index (BMI) of 25 kg/m² at age 18 (overweight) and BMI of 30 kg/m² at age 18 (obesity), 11.7% of the males (ranking second highest among the six countries) and 9.8% of the females (ranking third lowest in the six countries) were classified as overweight. The corresponding figures for obesity for males and females were 3.1% (ranking second highest among the six countries) and 1.8% (ranking third highest in the six countries) (Cole, Bellizzi, Flegal, & Dietz, 2000).

2.1.4 Motor development

One of the major studies on the development of preschool Hong Kong children is the Preprimary Project (PPP) of the International Association for the Evaluation of Educational Achievement (IEA) (Oppen, 1996). The data was collected in the late 1980s and included about 3 000 children aged 3 to 5 years old recruited through a two stage stratified sampling procedure. There were three stratum descriptors: locality, type and size of preschools. The first stage involved proportionate random sampling of preschools according to locality, type and size. In the second stage, children were sampled from the selected preschools. In terms of gross and fine motor skills, except for a few minor variations, Hong Kong preschool children seemed to be following the gross and fine motor development norms in other western countries such as the United States (Oppen, 1996). For self-care skills, Hong Kong children were at the same level as most of their American counterparts, but were ahead in some items (e.g. washing face) and behind in some others (e.g. hanging up clothes).

More recently, a survey using the Functional Independence Measure (WeeFIM), an instrument measuring a child's essential daily functional skills, was conducted. Four hundred and forty-five normal Chinese children aged 6 months to 7 years in the

community were recruited from MCHCs and kindergartens. Results showed that Chinese children scored better than their American counterparts in self-care (8 items) in all ages, and in mobility (5 items) until 36 months (Wong, Wong, Chan, & Wong, 2002). However, it must be cautioned that for the MCHC sample, only those who had passed the developmental screening tests were included in the study. It is possible that children with significant developmental delays might not be well-represented.

In a survey of 255 Chinese preschool children aged 4 to 6 years, using the Movement Assessment Battery for Children (Movement ABC), it was found that Chinese children performed significantly better on items contained in the manual dexterity (e.g. threading beads) and balance sections (e.g. walking on tip toe) than American children. American children were better at the projection and reception of moving objects (e.g. rolling a ball through a goal and catching a bean bag) (Chow, Henderson, & Barnett, 2001).

To sum up, from the above surveys, Hong Kong children are in general comparable to American children in motor development, with some minor variations.

2.2 Use of preventive services

2.2.1 MCHC coverage

In Hong Kong, there is a network of MCHCs offering a comprehensive range of health promotion and disease prevention services to children from birth to five years old, and women of childbearing age. In 2000, about 95% of all local newborns received services from MCHCs (Department of Health, 2002a). The respective figures for the years 1995 to 1999 ranged from 92% to 96%.

2.2.2 Childhood immunization rate

Childhood immunization rate is a reflection of the extent to which children are protected from serious vaccine-preventable diseases (Federal Interagency Forum on Child and Family Statistics, 2003). The percentage of children receiving the third dose of DPT (combined diphtheria, pertussis and tetanus vaccine) indicates how well countries provide routine immunization (UNICEF, n.d.b.). The coverage rate for industrialized countries in 2001 is 94% (Australia: 92%; Denmark: 97%; Finland: 99%; Iceland: 84%; Sweden: 99%; U.K.: 94%; U.S.A.: 94%) (UNICEF, 2003; Ministry of Health, 1998). In Hong Kong, a territory-wide immunization coverage survey was conducted in 2003 by DH. The survey included 3 345 children attending kindergartens and childcare centres selected by stratified cluster sampling method (participation rate: 93.5%). For local born children, the estimated coverage rates for the third dose of DPT were 99.9% (children born in 1997), 99.7% (children born in

1998), 99.9% (children born in 1999) and 100% (children born in 2000). The corresponding figures for Mainland-born children were 98.8%, 98.9%, 100% and 100% respectively (Tse & Yeung, 2004). The 2000 coverage rates for the booster dose at primary 1 and primary 6 were 99.2% and 99.4% (Department of Health, 2002a). The immunization rate in Hong Kong is therefore among the best in industrialized countries.

2.3 Childcare/rearing practices

2.3.1 Breastfeeding

Human milk is considered the best source of nutrition (Khin, Cheung, & Loh, 2002). According to the annual breastfeeding surveys conducted by the FHS (DH) in its network of MCHCs, the percentage of babies ever breastfed increased from 50% in 1997 to 66.6% in 2002. The percentage of babies exclusively breastfed beyond one month increased from 14% in 1997 to 23.9% in 2002. The percentage of babies exclusively breastfed for four to six months increased from 6% in 1997 to 13% in 2002. The percentage of babies who continued breastfeeding beyond one year increased from 2% in 1997 to 4.4% in 2002. The most common reasons for stopping breastfeeding were “not enough milk” and “back to work”. The Hong Kong percentage of babies exclusively breastfed is still low compared with other developed countries. According to the UNICEF (2003), the world exclusive breastfeeding rate (below six months) was 39% for the years 1995 to 2001.

2.3.2 Nutrition

A diet sufficient in nutrients and calories is important to children’s health and development (Federal Interagency Forum on Child and Family Statistics, 2003). In a longitudinal study on 173 Hong Kong children born in 1984 from birth to 7 years of age, Hong Kong children were found to have a lower energy intake compared to their Australian counterparts, but higher level of protein intake over the first 5 years (Leung, Chan, Lui, Lee, & Davies, 2000).

In another study on children aged 2 to 7 years recruited from day nurseries and kindergartens in Hong Kong, among 3 028 questionnaires returned out of 220 000 distributed (in a booklet published by a commercial company distributed to about 90% of nurseries and 70% of kindergartens in Hong Kong in 1994), as many as 70% of these children were not eating sufficient vegetables and 30% were not eating the recommended amount of fruit (Hong Kong Dietitians Association, 1995). These studies pointed out that there were signs of high protein intake among Hong Kong children and fruit and vegetable intake were low.

Intakes of vitamin C and minerals were generally comparable to the U.S. Recommended Daily Allowance (Leung et al., 2000). Iron deficiency and vitamin D deficiency were not common among Hong Kong infants (Leung, Lui, & Swaminathan, 1989; Leung, Davies, Lui, Lo, Yuen, & Swaminathan, 1988). However, recent data from the routine neonatal thyroid screening programme in hospitals in Hong Kong revealed mild iodine deficiency among 22% of neonates in Hong Kong. This might be related to the borderline iodine intake of pregnant women in Hong Kong (Kung et al., 2001).

The available information on the nutrition status of Hong Kong preschool children is based on surveys with samples of different age groups and sizes, with different sampling frames and methods, some of which were conducted in the 1980s and early 1990s. Based on these figures, there is some indication that unbalanced diet is an issue of concern.

2.3.3 Oral health

A survey on the oral health of 3 733 5-year-old children was conducted by the DH in 2001. It was found that tooth decay was unevenly distributed and mostly untreated. About half of the 5-year-old children were not affected by tooth decay but 23.6% had around 78% of all the teeth affected. More than 90% of the decayed teeth were left untreated and dental abscess was found among some children. It was also found that over 40% of children brushed their teeth less than twice per day and over 30% of the children never had adult assistance in brushing their teeth. About 20% of the children had frequent snacking, and over 70% of the children had never seen a dentist at age 5 (Department of Health, 2002b).

For international comparisons, the dmftⁱ of 5-year-old children in Hong Kong is 2.3, which is better than the dmft values of neighbouring regions (Mainland China: 4.5; Macau: 4.5ⁱⁱ; Malaysia: 5.8) but not as good as some developed countries (Australia: 1.4; England & Wales: 1.6; U.S.A.: 1.8) (WHO, n.d.).

ⁱ dmft is a means to numerically express the caries prevalence for primary dentition and are obtained by calculating the number of Decayed (d), Missing (m), Filled (f) teeth (t). It is used to get an estimation illustrating how much the dentition until the day of examination has become affected by dental caries. The sum of the three figures forms the dmft-value (WHO, n.d.).

ⁱⁱ The data for Macau and U.S.A are for 6 year olds which are commonly used to “substitute” 5-year-old data for comparison when the latter information is not available.

2.3.4 Physical activity

In a study on the activity level of 148 preschool children in Hong Kong, it was found that boys were more active than girls; 4 and 5-year-old children were more active than the 3-year-old. In terms of the energy expenditure, most children were performing at the low to moderate levels of physical activity. The lack of sufficient physical space in Hong Kong preschools was regarded as one of the reasons for the low activity level (Louie & Chan, 2003).

In a study on 171 boys and 119 girls in 5 preschools, each child wore a pedometer and a TriTrac (triaxial accelerometer, recording data minute by minute) on the waist during school days and weekends. The children's physical activity level (by both pedometers and TriTrac) was higher during weekends (Saturday and Sunday) but lower during school days. Total pedometer step counts were Friday (10 501; 11.5 hoursⁱⁱⁱ), Saturday (15 982; 13 hours), Sunday (13 010; 12 hours) and Monday (10 085; 13 hours). These figures are lower than the WHO standard of 13 000 to 16 000 steps per day for children (「港童步行量」, 2003; B.C. Chow, personal communication, November 11, 2003).

Though there is some concern about the low level of physical activities among Hong Kong preschool children, it must be pointed out that the information available is fairly limited and is based on relatively small samples. The results should be interpreted bearing these points in mind.

2.3.5 Exposure to environmental tobacco smoke (ETS)

In a population-based prospective birth cohort study involving a sample of 7 890 infants born in April and May 1997 visiting MCHCs, it was found that 4.6% of the mothers were ever smokers since conception and 33.6% of the fathers reported smoking at the first baseline visit. For the non-smoking mothers, 65% reported ETS exposure during their pregnancy (50.5% with occasional exposure and 14.2% with daily exposure). There were 41.2% of infants exposed to ETS at home via smoking by fathers or others. The study also indicated that prenatal exposure to ETS through the mother was associated with more consultation visits and higher hospitalization rates in infants (Lam, Leung, & Ho, 2001).

2.3.6 Unintentional childhood injuries

Injuries are the leading cause of death among children aged 1 to 14 in Hong Kong, but at the same time, they are amongst the most preventable of all childhood conditions (Department of Health, 1998). The average annual mortality rate for

ⁱⁱⁱ Hours per day that the child wore the pedometers

unintentional injuries during the years 1990 to 1995 were 4.8 per 100 000 for boys and 3.0 per 100 000 for girls. Boys (Hong Kong Childhood Injury Prevention and Research Association, 2002a) and children under 5 are more prone to unintentional injuries (Department of Health, 1998; Chan et al., 2003). In 2000, the death rate due to injury and poisoning for children aged 1 to 4 was 3.7 per 100 000 (Department of Health, 2002a). The overall mortality rate in children due to unintentional injuries is low compared to U.S.A. (12 per 100 000) and U.K. (boys: 61.4 per 1 million; girls: 47.4 per 1 million) (Federal Interagency Forum on Child and Family Statistics, 2003; National Statistics, 2000).

The home is the place where most childhood injuries occur (Department of Health, 1998). In a surveillance study of unintentional childhood injury in Hong Kong between 1999 and 2001, based on 18 919 children under the age of 16 attending the Accident and Emergency Departments of three local hospitals for injury or poisoning, 26.8% were identified as unintentional residential childhood injuries (URCI). For children aged 4 or under, about 50% of the injuries took place at home (Hong Kong Childhood Injury Prevention and Research Association, 2002b). In a more recent study based on telephone interviews with caregivers of children and adolescents (under 16 years old) admitted to three Accident and Emergency Departments for URCI, it was found that the living room or bedroom were the places where most of the injuries took place (Chan et al., 2003).

The most common unintentional injury is accidental falls (Chow et al., 1999; Hong Kong Childhood Injury Prevention and Research Association, 2002a) and this is also the commonest cause of injury deaths in children under 5 (Department of Health, 1998). In the Hong Kong Childhood Injury Prevention and Research Association (2002b) study, it was found that falls, struck by others, and motor vehicle related injuries were the most common external causes of injury, and there were more boys than girls injured. In the Chan et al. (2003) study, “contact with blunt force” (e.g. fall from height, slipping and falling, tripping) was found to be the leading mechanisms in all age groups. The second leading mechanism for children under the age of four was “thermal and radiant mechanism”. Similarly, in a survey of children aged 0 to 15 admitted to the Accident and Emergency Department of a teaching hospital in Hong Kong between 1996 and 1997, it was found that for external causes of injury among children under 2, poisoning, falls and scalds dominated (Chan et al., 2000).

In a study of 1 063 hospitalized burn patients in the same teaching hospital admitted between 1993 and 1999, it was found that 235 (42.7%) of the admitted patients were toddlers under 2 years old (Ho & Ying, 2001). Scald was the cause for the majority of burns, especially among paediatric patients.

In another study on fractures, based on 6 389 inpatient children younger than 16 years admitted to one hospital, it was found that there were more boys than girls affected. The most common fractures for children aged 0 to 3 years were supracondylar fractures of the humerus (26.7%) and forearm shaft fracture (17.8%). The most common fractures for children aged 4 to 7 years were supracondylar fractures of the humerus (31.7%) and distal radius fracture (16.4%) (Cheng, Ng, Ying, & Lam, 1999).

Comparison with international data revealed that for external causes of injury, falls were more frequent while poisonings and burns were less frequent in Hong Kong (Chow et al., 1999; Chan et al., 2000).

In general, in terms of unintentional childhood injuries, the Hong Kong mortality figures are somewhat lower than international figures. However, the official statistics include only mortality rates due to injuries and systematic information on non-fatal injuries is limited. The available information is based on short-term surveillance studies of admissions to a small number of hospitals, with different target samples, and they may not be representative of the whole population. The morbidity data may be an underestimation, as a lot of the non-fatal childhood injuries are presented to general practitioner instead of Accident and Emergency Departments, or treated at home.

2.3.7 Child abuse

Apart from unintentional injury, another source of childhood injury comes from child abuse, which is defined as “any act of commission or omission that endangers or impairs a child’s physical/psychological health and development” (Social Welfare Department, 1998, p.1). It includes physical abuse, sexual abuse, neglect and psychological abuse^{iv}. The adverse developmental consequences associated with child abuse include loss of attachment, lower self-esteem, fewer interpersonal relationships, sexualized or aggressive behaviour, substance use, dissociation, self-injury or other dysfunctional ways of coping with anxiety and stress (WHO, 1997). At present, the statistics on child abuse is captured by the Child Protection Registry (CPR) which is administered by SWD. Other than statistical purpose, the CPR also carries the functions of case registration and case checking by social workers and related professionals. However, in Hong Kong, there is no mandatory reporting law for child abuse (Tang & Davis, 1996) and it is possible that the CPR figure is an underestimation of the situation. The 2001 to 2003 statistics are shown

^{iv} It is recognized that child abuse involves various domains of health but for simplicity in presentation, this issue is presented under the physical domain.

in Table 2. Approximately 20% of the victims of child abuse are children aged 0 to 5.

Table 2
2001 - 2003 figures on newly registered child abuse cases

Types of abuse	2001	2002	2003
Physical abuse	306 (57%)	292 (56%)	277 (58%)
Neglect	29 (5%)	17 (3%)	20 (4%)
Sexual abuse	152 (29%)	179 (35%)	150 (31%)
Psychological abuse	17 (3%)	11 (2%)	4 (1%)
Multiple abuse	31 (6%)	21 (4%)	30 (6%)
Total	535 (100%)	520 (100%)	481 (100%)

Source of information: Social Welfare Department

While the above figures are based on official statistics of reported cases, a community survey was conducted in 1995 where 1 019 households with a child at or under 16 were randomly selected from the telephone directory (4 264 valid contacts made, 2 306 unavailable for interview, 940 refusal to participate, participation rate: 23.9%). The base rate was 526 per 1 000 children for minor violence (throw something at, push, grab, shove; and slap or spank), and 461 per 1 000 children for severe violence (kick, beat, hit with a fist, hit or try to hit with an object, beat up, threaten with a gun, knife, or other weapons, use a gun, knife or other weapons). It was found that children between 3 to 6 years old (among age groups 0-2, 3-6, 7-12 and 13-16 years) were the most likely to experience child violence by their parents (Tang, 1998). In comparison with a United States national survey using the same methodology and the same measuring scale, Hong Kong families showed lower rates of minor violence but higher rates of severe violence.

In a more recent household survey involving 1 622 interviews with parents with children under 18 years old, using the Conflicts Tactics Scale, 18.35% of the total sample fulfilled the research criteria for child abuse, being “*either* frequent occurrence of physically violent behaviour, *or* moderately frequent occurrence of multiple forms of abusive behaviour” (Tang, 1999a, p.84). One of the major reasons for parents to engage in child abusive behaviour was to solve child-related management problems (Tang, 1999a).

The survey figures are higher than the SWD figures. As mentioned before, the SWD figures are likely to be an underestimation of the prevalence of child abuse. If the survey figures are true reflections of the present situation, then a considerable number of children are subject to child abuse. Most of the available information is

on physical abuse, and there is relatively less information on other forms of abuse.

2.3.8 Views from stakeholders

In the focus group discussions, participants pointed out their concerns in the physical domain of child health which were mainly related to lifestyle issues. Preschool workers, parents, academics, and health professionals were concerned about issues such as nutrition, obesity and physical fitness. These views are consistent with the literature on nutrition problems and lack of physical activity among Hong Kong children. The following are examples of the views of the participants:

In fact, I am not too worried about the health service for preschool children in Hong Kong. Why? Basically, the services of hospitals, as well as MCH (centres) are very good. However, I discover that the greatest problem is the education system, or even the social system. Why? We put too much emphasis on academic knowledge, too much emphasis on achievement, and so students do not exercise much. Without exercises, it is easy to age and there are lots of diseases. Nowadays, (we) say that for half of the diseases, the risk can be reduced through exercises. (Group 14: I7)

One (issue) is nutrition. (If) I can provide good nutrition, then, of course there will be fewer diseases... Food fad is another problem. On the other hand, (we) have to look out for obesity. (Group 15: C20)

Furthermore, a point which was raised very strongly by many paediatricians was the lack of health indicators and a central information system. This posed difficulties for understanding the current situation and service planning. They explained their viewpoints as follows:

At the beginning (of the focus group discussion), someone mentioned health indicators. I think that this is very essential. For example, in development, I dare say that basically, there is no condition...where there are some very clear health indicators for Hong Kong, not to say Hong Kong, but there is none in neighbouring (places). Thus, in many cases, in planning and professional training, (we) cannot deal with the work. This is really very important...Also, for the data, there is really no system for me to know that you have already counted (the data) somewhere and the (particular) child's data has been reported to me three times. (Group 14: K33)

2.3.9 Summary

The available information suggests that Hong Kong is doing well in terms of infant and under 5 mortality rate, as well as immunization rate. However, there is

concern about child abuse, obesity, unbalanced diet, low physical activity, oral health and breastfeeding rates.

It is pointed out by the stakeholders that health indicators, in the various domains, need to be developed to regularly monitor the health of children in these areas and to provide information for service planning and provision. The stakeholders' view about indicators is consistent with the concerns raised in the review of the current literature on the health status of Hong Kong preschool children. It has been pointed out that the available studies employ different tools, different sampling frames and methodologies, making comparison difficult.

3. Cognitive domain

3.1 Cognitive skills

Information on the cognitive status of Hong Kong preschool children is limited. In the IEA Preprimary Project (Oppen, 1996), when compared to their North American counterparts, the Hong Kong sample appeared to be slightly ahead on the acquisition of various basic concepts such as “heavy”, “rough/smooth”, “day/night” and “left/right”. In the WeeFIM study mentioned before (Wong et al., 2002), Hong Kong children were doing better than American children in the cognition area of the WeeFIM until 42 months. However, the limitations of the study should be pointed out. First, there were only 5 items measuring cognitive skills (understanding of language, expressive use of language, social interaction with peers, problem solving, and memory). Second, for children aged 6 months to 5 years old from MCHCs, only those who had passed the developmental screening tests were included in the study. Thus children with significant developmental delays were not well-represented. Bearing in mind the limitations of the studies, and based on the limited evidence available, the general picture is that Hong Kong children are comparable to American children in cognitive development.

3.2 Numeracy skills

In the IEA Preprimary Project (Oppen, 1996), Hong Kong children were comparable to American children in most areas of numeracy skills and they acquired some concepts at an earlier age than American children. These included concepts of first, last, middle, rote counting, counting objects, knowing numerals beyond 10, knowledge of less within 1 to 10, half-whole relationship, time by hours, number of fingers on both hands, simple addition within 5, coins and ordering four circles. In another study on numeric skills, Hong Kong 4 and 5-year olds were found to surpass their English and American counterparts in rote counting, place value numeration and embedded ten cardinal ($10 + y$) understanding (Ho & Fuson, 1998). However, the

sample size in this study was fairly small (12 to 36 Chinese children).

Based on the above limited evidence, Hong Kong children are comparable to their peers in numeracy skills, and they are more advanced in some areas.

3.3 Prewriting and literacy skills

In a study comparing Hong Kong preschool children with their counterparts in Beijing and Singapore (160 children in each society), it was found that Hong Kong 4 to 5-year-old and 5 to 6-year-old children performed better on the Preschool and Primary Chinese Literacy Scale (character identification, visual and auditory discrimination and word recognition) than their counterparts, even after controlling for maternal education level (Li & Rao, 2000). However, it should be pointed out that the participants were chosen from middle class kindergartens in the three societies and they might not be representative of other children in these three societies.

In the IEA Preprimary Project (Opper, 1996), Hong Kong children were ahead of their counterparts elsewhere in drawing two and six to seven body parts, drawing a house, copying first name and writing own name, copying triangle and diamond and writing numerals from 1 to 19. In most other areas, they were comparable to their counterparts.

In short, based on the few studies available, Hong Kong children are comparable to their age peers in other countries in their literacy and prewriting skills. In some areas they are more advanced than their counterparts.

3.4 Language development

There are a number of studies on the language development of Hong Kong preschool children.

In one of the studies based on 268 children, it was found that by the age of two, most children had mastered the contrastive use of tones and vowels. The consonants acquisition order was similar to that reported for English. After the age of four, few phonological errors were made (So & Dodd, 1995).

In a large scale study involving 1 625 Hong Kong children recruited from five MCHCs in Hong Kong of age between 8 and 30 months, it was found that the average vocabulary size of 16 to 22-month-old children was 98 words and that for 23 to 30-month-old children was 434 words, representing a four-fold increase (Fletcher et al., 2004).

In the IEA study (Opper, 1996), Hong Kong children were found to achieve most language skills at around the same age as children elsewhere. Hong Kong children were ahead of their counterparts in following 3-step instruction, telling the use of four

senses, naming seven days of the week and naming eight animals in one minute.

In a study based on focus groups with parents of preschool and primary school students (家庭與學校合作事宜委員會, 1995), it was found that most parents thought that children could start learning English and Putonghua during the preschool years and it was important that children should acquire a second language. Parents thought that it was too late to start teaching English in the senior primary school years. Though they were in favour of using Chinese as the medium of instruction, they would like to keep the present load of English teaching.

In terms of language development, Hong Kong children are comparable to their counterparts in other countries, based on the limited information available.

3.5 Preschool attendance

It is recognized that participation in pre-primary education programmes can provide preschool children with skills and enrichment that can increase their chances of success (e.g. academic achievement, school completion rate) in school (Federal Interagency Forum on Child and Family Statistics, 2003). It is noted that universal but voluntary preschool programmes are available in advanced industrialized countries and just about all or almost all children aged 3 to 5 years are attending some forms of preschool programmes (Kamerma & Kahn, 1994). For example, in Canada, senior kindergarten is available to all 5-year-olds in Ontario though attendance is voluntary and the attendance rate is about 95% (McCain & Mustard, 1999). In Hong Kong, among children aged 3 to 5, 94.7% were attending preschools (Census and Statistics Department, 2002a). Generally speaking, the Hong Kong preschool attendance rate is comparable to other advanced industrialized countries.

3.6 School readiness

In a study involving 32 primary one students by group interviews using semi-structured questions, it was found that most students had little difficulties with peer or teacher-student relationship. These children had difficulties in adapting to the relatively rigid rules in primary schools and they complained about the amount of homework, as well as frequency of tests and examinations. Moreover, the low achievers preferred kindergarten where they were not scolded by their teachers. Teachers reckoned that most students had adjusted to primary school life by the middle of the first semester. One fourth of the parents interviewed maintained that their children experienced little difficulties in adjusting to primary school life (Wong, 2003).

3.7 Views from stakeholders

In the focus group discussions, most participants felt that Hong Kong preschool children were doing well in terms of cognitive development. One participant explained this point in the following quote:

I think that children are very quick in learning...Circumstances allowing, (I) will let him (my child) learn more, so that he can develop better. If I see something good in him, I will strengthen the training. (Group 9: D1)

Consistent with the above quote, one of the most commonly mentioned issues in this area was about “enrichment activities” and the acquisition of a second or third language. The views of the participants on this issue, were, however, divided. Preschool workers, social workers, most health professionals, academics and some parents pointed out that parents were too keen for their preschool children to acquire a second or a third language, and to learn many other things, such as musical instruments. They felt that this was an issue of concern. Three of them explained this situation as follows:

I discover that in the past one to two years, parents increasingly like to send their children to learn this, learn that, and learn that. If you are talking about more extreme examples, (we are) talking about parents who have things (for their children) to learn from Monday to Friday, and the whole summer holiday is full. (Group 2: E13)

For example, (for children) just over one year old, (parents) are asking whether we (crèche workers) will teach English, whether (we) will talk to the child in English. (Group 3: B25)

The parents think about everything. They (children) should develop multiple intelligence. Therefore, they take them (children) to learn music, dancing, English, and then other new things. I think the children are having a hard time. (Group 7: A29)

On the other hand, some of the participants, mostly parents, mentioned the need for children to acquire a second language early. These views are consistent with the research on parents’ attitudes in section 3.4. Below are some examples of this view:

I don’t know whether this is correct or not, but at preschool stage, (we) need to help them (children) learn other languages. (Group 6: G16)

Yes, that is, education, (I) really would like (my child) to learn more, learn English at a young age. (Group 10: A100)

3.8 Summary

Apart from the IEA survey and the Fletcher et al. (in press) study, there are not many large scale studies which can provide a broad general picture of Hong Kong

preschool children's cognitive and language performance. Many of the available studies are of relatively small scale on fairly specific issues. Different measures are used in different studies. Nonetheless, the available information suggests that Hong Kong children are in general, comparable to their peers in western societies in the areas assessed. However, some stakeholders were concerned about parents enrolling their children in many outside-school classes (e.g. music classes, language classes). It is not clear whether these "enrichment activities" are actually effective in promoting children's development or whether they contribute to children's stress and anxiety.

4. Social emotional domain

It is found that children who exhibit conduct problems at an early age are at a higher risk of adolescent conduct problems and delinquency (Earls, 1994; Patterson, Forgatch, Yoerger, & Stoolmiller, 1998; Ferugsson, Horwood, & Nagin, 2000; Moffit & Caspi, 2001). There is also a link between childhood emotional disorders and adult psychotic symptoms (Poulton et al., 2000; Geller, Zimmerman, Williams, Bolhofner, & Craney, 2001). If these early childhood problems are not addressed, the resulting human, social and economic costs to the community are considerable.

In terms of the prevalence of behaviour problems among preschool children, an earlier survey among Hong Kong children aged 36 to 48 months estimated the prevalence rate of mild, moderate and severe behaviour disorder at 17.90%, 4.55% and 0.75% respectively (Luk et al., 1991).

In a household survey involving 1 662 interviews with parents with children under 18 years old, using the Child Behaviour Checklist, the prevalence of internalizing and externalizing behaviours was estimated at 10.3% and 18.9% respectively (Tang, 1999a).

In 2002/2003, the DH conducted a survey on child behaviour problems and parenting issues with 942 clients of MCHCs with 4-year-old children (participation rate: 67.0%), using the Eyberg Child Behaviour Inventory (ECBI) (Eyberg & Pincus, 1999). The sample was drawn using a multi-stage cluster sampling method. About 10% of children were classified as being above the clinical cut off scores using the Eyberg and Pincus classification (cut off scores) (Department of Health, 2003). According to Eyberg and Pincus (1999), children whose scores are above the cut off "should be identified for further evaluation aimed at diagnosing potentially significant psychopathology" (p. 17) and the parents are significantly bothered by the behaviour problems of the children. The Eyberg and Pincus (1999) cut off scores are reasonably consistent with the findings in the validation study of the Chinese version of the ECBI in Hong Kong (Leung, Chan, Pang, & Cheng, 2003) in that the cut off scores are fairly close to the mean scores of the referral case group (children referred

for psychological services because of behaviour problems). The results also suggested that children above the clinical cut off scores were not restricted to any particular social class groups.

The figures from the various surveys are consistent with studies on the prevalence of problem behaviours in preschool children internationally, where the consensus was that approximately 10% to 15% of preschool children had mild to moderate problems (Campbell, 1995).

For personal and social skills, in the IEA study (Opper, 1996), it was found that Hong Kong children were behind their American counterparts in social skills of politeness (e.g. greeting people) and some play skills (e.g. co-operative play) but were earlier in selecting a friend. In terms of self-awareness, Hong Kong children were found to be similar to their counterparts elsewhere for knowledge of sex, age, number of siblings and date of birth. They were ahead of others in knowing their full name. It was also noted that there was a discrepancy between children's social competency scores reported by parents and preschool teachers. Preschool teachers reported a steady age progression in social competency (e.g. performing tasks, communicating needs) but there was no age change from the parents' reports. However, it is not clear whether these are real differences or differences in teachers' and parents' perceptions.

In a survey involving 2 342 parents recruited from MCHCs, day nurseries and kindergartens, using a multi-stage random sampling method (participation rate: 89.9%), it was found that parents of preschool children were concerned about behaviours associated with hyperactivity (e.g. hyperactive, poor concentration, agitation), and poor habit formation (e.g. dependence, poor eating habits, sharing with other children). Parents with older children (6 to 15 years old) (recruited through primary and secondary schools) were concerned about disobedience and learning problems (Chinese University of Hong Kong, 2002).

In the focus group discussion with stakeholders, one of the issues mentioned by all sectors, including parents, preschool workers, social workers, academics, and health professionals was that Hong Kong children lacked social skills, in the sense that they did not know how to share with others, nor did they have social problem solving skills.

For example, how to share with other people, or ... how to negotiate with others...This is relatively difficult for them, because they feel that most things are theirs. Therefore, when (we) explain to them, they don't understand. So why should I share with you? At home, every thing belongs to me. Therefore, I think that this problem is fairly serious for this generation's children. (Group 1: F1)

In addition, preschool workers, parents, and academics also pointed out that children lacked coping skills and they expected others to solve problems for them. Below is a typical example:

For them (children), solving problems is more difficult to manage. This is because they feel that if I am unhappy, someone will solve (the problem) for me. In short, I will be unhappy and I will have temper tantrums...They (parents) do not require you to think of a way to manage (the problem). They (children) have the temper tantrum and you (parent) help me solve that. You let me have my way or I will continue the temper tantrum. (Group 2: K15)

In sum, there are a number of surveys on child behaviour problems among preschool children. The prevalence rate of conduct problems among Hong Kong preschool children is similar to that reported in international literature. Surveys on the social and coping skills of Hong Kong preschool children are relatively limited. This might be due to the lack of valid local instruments for measuring these constructs. Stakeholders, however, were very concerned about children's lack of social and problem solving skills. They felt that these difficulties were related to the home situation and parenting which will be discussed in section 10. The stakeholders' views were consistent with the limited available quantitative information on children's social skills.

5. Spiritual domain

The approach taken in this section is different from that in other sections. This is because there is little consensus about the definition of spirituality in the literature. It is necessary to consider the various definitions of spirituality first, before presenting information related to the spirituality of preschool children in Hong Kong.

Gardner (1999) regards spirituality as “a potential to engage in thinking about cosmic issues, which might be motivated by pain, powerful personal or aesthetic experiences, or life in a community that highlights spiritual thinking and experience” (p.59). Gardner uses the term existential intelligence, or a concern with “ultimate” issues to refer to the cognitive side of the spiritual. According to Gardner, the core ability of existential intelligence includes “the capacity to locate oneself with respect to the furthest reaches of the cosmos – the infinite and the infinitesimal – and the related capacity to locate oneself with respect to such existential features of the human conditions as the significance of life, the meaning of death, the ultimate fate of the physical and the psychological worlds, and such profound experiences as love of another person or total immersion in a work of art” (p. 60).

There are other definitions of spirituality which include aspects other than the cosmic or transcendent issues. For example, from an organizational psychology

point of view, Knoz and Ryan (1999) define spirituality as “the human person in all its richness, the relationship of the human person to the transcendent, the relationship between human persons, and the way to achieve personal growth” (p. 202-203). Robbins (2003) discusses spirituality in terms of people seeking to “find meaning and purpose in their work, and desire to be connected with other human beings and be part of a community” (p.243). Garcia-Zamar (2003) maintains that the core idea in spirituality is interconnectedness. From a mental health point of view, Chan, Chan, and Yau (2004) conceptualize spirituality in terms of a positive attitude towards life and perceiving difficulties as challenges. Spirituality as such is positively correlated with life satisfaction, self-esteem and negatively correlated with perceived stress (C.L.W. Chan, personal communication, January 13, 2004). Sperry (2001), from a psychotherapy perspective, defines spirituality as “meaning and belonging and the core values that influence one’s behaviour” (p. 4). From a health perspective, O’Donnell (1986) conceptualizes spiritual health as including the elements of love, hope, charity and purpose. From an education perspective, Wright (2000) defines spirituality as “our concern for the ultimate meaning and purpose of life” (p. 7). Locally, Pang, Wong, and Leung (2002) conceptualize spirituality as consisting of four aspects, self-awareness and self-knowledge (自我認知); self-reflection (自我反省); appreciation of life and valuing of love (欣賞生命); and contributing to society and purpose of life (貢獻世界). In these definitions, the emphasis is on human relationship, meaning or purpose of life and personal growth.

There are also a number of stage theories on spiritual development but few of them relate the stages to age groups. The stage theories, however, are not without criticisms. They are criticized as being unidimensional in many cases and there is no information on the cultural appropriateness of the stage theories either (Sperry, 2001). The following is a description of the only stage theory where age groups are specified, in the present literature search, and it is presented to give the readers an idea of stage theories. According to Lovecky (1998) and Sperry (2001), the infant stage is a pre-stage where children learn about faith through developing basic trust in people. Through forming relationships with people, empathy, reciprocity and spirituality develop. Children aged two to seven are in the intuitive-projective stage. Children at this stage cannot completely differentiate reality from fantasy. There is some emerging awareness of individual feelings and experiences but children are still egocentric. Children aged seven to twelve are at the mythical-literal stage. They are more able to differentiate between reality and fantasy, and to consider other people’s perspectives, and are aware of reciprocal fairness and justice. However, their understanding of beliefs and symbols are still quite literal. Young people aged 12 to 21 are in the synthetic-conventional stage and they develop their own personal

ideology and independent identities. Their beliefs and ideologies are still, to a large extent, conformist. Three more stages beyond the synthetic-conventional stage are postulated. The individuative-reflective stage is where people take on a personal system of meaning to which they are committed personally. The conjunctive stage is the stage where people are ready to synthesize opposite ideas and the final universalizing stage is the stage where one seeks to relate to others in a just and loving way.

There is some resemblance between the issues described in the stage theory of spiritual development and moral intelligence. Borba (2001) defines moral intelligence as the capacity to understand right and wrong, having strong ethical convictions and acting on them. Moral intelligence consists of seven essential virtues, namely, “empathy, conscience, self-control, respect, kindness, tolerance and fairness” (p. 6). According to Gardner (1999), a moral sense entails the capacity to make judgment about issues such as “rules, behaviours, and attitudes that govern the sanctity of life – in particular, the sanctity of human life, and in many cases, the sanctity of any other living creatures and the world they inhabit” (p. 70). Hay, Castle, and Jewett (1994) discuss the dimensions of character development. These include sensitivity to the needs of others, provision of care, cooperative orientation, helping others, social problem solving skills, honesty and trustworthiness, adherence to social and moral conventions and norms, self-regulation, self-evaluation and self-reflection. Gardner, Borba, Hay et al. and the stage theorists, though using different terms, are similar in their emphasis on the issues of respect for others and adherence to social rules and conventions. Borba reckons that moral intelligence affects every aspect of children’s lives, as well as “the quality of their future relationships, professions, productivity, parenting skills, citizenship” (p. 12).

Summing up from the above definitions, the concept of spirituality (as well as the related concepts of moral intelligence and character development) could include a concern with “transcendent issues”, meaning of life, positive attitude towards life, personal growth, interpersonal relationship and social connectedness, as well as fairness and justice.

While it is recognized that spirituality is an important issue (Choi, 2004), there is limited literature on children’s spirituality. Many of the research projects on children’s spirituality make use of qualitative methods such as extended conversations or unstructured group interviews with children, or adult recollection of childhood experiences (Wright, 2000). The content is mainly related to ultimate meaning and purpose of life.

Literature search using electronic databases such as PsyINFO reveals that there is some limited information on the moral development of Hong Kong preschool

children. A recent study with 61 Hong Kong 3 to 6-year-old children from middle class families examined their conceptions of moral, social-convention and personal events (Yau & Smetana, 2003). The moral events were related to hurting and teasing. The social-conventional events were related to a child calling the teacher by the first and last name, and eating with fingers. Personal events were related to choice of snacks, playmates and free time activity. It was found that the Chinese children viewed moral transgressions as less permissible, more serious, and more wrong than social-conventional transgressions. Chinese children were found to consider moral transgressions in terms of the intrinsic consequences of the acts for the welfare of others and fairness. American middle class children, on the other hand, considered moral transgressions as bad but they were not able to specify the reasons. In interpreting the results, it should be cautioned that the present study consisted only of a small sample of middle class Chinese children.

Another study examined the concept of distributive justice among 60 children from one kindergarten and one day nursery. The children were between four to five years old. They were interviewed individually and “instructed to decide whether the characters in the story should share their toys with a latecomer in four different situations” (Wong & Nunes, 2003, p. 122). It was found that these preschool children were more sensitive to the characteristics of the recipients, compared with that in western literature. The children’s allocation decision depended on the characteristics of the recipients and number of items allocated was related to the age of the recipient, with younger recipients receiving more items (Wong & Nunes, 2003).

In the Pang et al. (2002) study on Hong Kong primary and secondary students, teachers were requested to rate students’ performance in various domains. It was found that girls scored higher than boys on the moral (德), social (群), aesthetic (美), emotional (情) and spiritual (靈) domains. The cognitive (智) domain was found to be highly correlated with the spiritual domain. It was also found that the students could reach the basic performance (基本表現) levels in all areas only in the moral, physical (體) and emotional domains. In terms of the spiritual domain, students were below the basic performance level in the areas of self-reflection and purpose of life. There is, however, little information on the psychometric properties of the teachers’ rating scale.

In terms of interpersonal relationship and social connectedness, there are a few studies on pro-social behaviour among Hong Kong upper primary and secondary students but no study on Hong Kong preschool children could be found. In a longitudinal study involving 150 secondary school students from six secondary schools in Hong Kong, data was collected over a two-year interval. It was found that parent-adolescent conflict was predictive of antisocial behaviour (Ma & Shek,

2001). In another study with 71 secondary school students, it was found that students with good parent-child and peer relationships reported lower frequencies of antisocial behaviour (Ma, Shek, Cheung, & Lam, 2000). In a study involving 232 primary school students in grades 4 to 6, it was found that altruistic orientation was related to family social environment, peer influence and peer relationships. Girls reported higher altruistic orientation scores than boys (Ma, 2003). All these studies consistently point to the relationship between family relationship and pro-social behaviour. One might argue that if we want preschool children to develop into pro-social adolescents, good family relationship is important.

For purpose of life, in a longitudinal study on adolescent psychological morbidity, it was found that relative to life satisfaction and hopelessness, self-esteem and purpose in life were stronger predictors of psychological morbidity over time (Shek, 1998). The participants were 378 secondary school students selected from secondary schools in Hong Kong, using stratified-cluster sampling method, with student academic ability as the stratifying factor.

To sum up, the limited evidence on Hong Kong preschool children, based on two small samples, suggests that they are comparable to the age peers in the west in moral judgment and distributive justice. There is also evidence to show that family relationship is an important predictor of adolescent pro-social behaviour.

During the focus group discussions, participants from the preschool and social service sectors, as well as parents, pointed out the importance of respect for people, social connectedness, proper values and morality. Below are some typical examples:

In our day nurseries, from different districts, from different social classes, the same phenomenon occurs, that is, not knowing how to respect people. (Group 1: D45)

I think, in this society, the spirit of “loving oneself, loving others” is lacking. (Group 2: O83)

Therefore, a proper value system, morality, should be learnt in schools. (Group 4: E41)

I hope to cultivate a real person, to have the dignity that one should have as a person and the right value system. (Group 7: B169)

6. Children with developmental problems

6.1 Central Referral System for Rehabilitation Services data

Children with developmental problems are likely to need more specialized health care and special education service provisions. In Hong Kong, “the Central Referral System for Rehabilitation Services (CRSRehab) covers rehabilitation services for disabled preschoolers, mildly mentally handicapped children, mentally and/or

physically handicapped adults, ex-mentally ill persons, and the aged blind persons in day training and residential care” (Social Welfare Department, 2000, p. 1). Accordingly, there are 5 subsystems in the CRSRehab catering for people with different disabilities, namely: subsystem for disabled preschoolers (CRSRehab-PS), subsystem for the mentally/physically handicapped (CRSRehab-MPH), subsystem for the ex-mentally ill (CRSRehab-ExMI), subsystem for the aged blind (CRSRehab-AB), and subsystem for supported employment (CRSRehab-SE). The current CRSRehab-PS figures (March 2004) for children 0 – 6 are listed in Table 3. It should be noted that children could have more than one disability.

The CRSRehab-PS figures are probably the best estimate of the number of preschool children with developmental problems though it is still dependent on the reporting of children being known to service providers who then register them with the system. From below, the areas with the largest number of children are intellectual disability and speech problems.

Table 3

Current CRSRehab-PS figures (March 2004) for children 0 – 6

Type of disability	0-2 years old	2-6 years old	Total
Physical	21	281	302
Spastic	9	96	105
Hearing	19	158	177
Vision	24	123	147
Intellectual	70	2 919	2 989
Speech	56	3 718	3 774
Autism	5	706	711

6.2 Child Assessment Service data

CAS (DH) serves children from birth to 12 and the figures on the functional diagnosis categories of new cases for the years 2001 and 2002 are listed below (Table 4). It should be noted that some children might have more than one diagnosis category and again, the figures only include children who have used the services.

The large increase in the number of children in the clumsiness/motor delay area is due to a new system of assessment in the year 2002.

The figures consistently indicate that the intellectual disability/developmental delay and language problems are the areas with the largest numbers of cases. However, all these figures are based on children who have accessed the services and the actual prevalence in the community is not known.

The quantitative figures, as mentioned before, are reflections of the number of

children with developmental problems who are known to service providers. However, the focus group participants reflected that there was a long process and delay before these children were referred and diagnosed. They pointed out that during this period, the parents and the children were facing considerable difficulties. Participants maintained that preschool workers did not have the training to make diagnosis or to offer appropriate intervention, without professional support.

Table 4

2001 and 2002 functional diagnosis categories of new cases in CAS (DH)

Functional diagnosis categories	2001	2002
Developmental delay	576	813
Language delay/disorders	1 098	1 410
Voice and articulation problems	1 202	1 132
Learning difficulties	227	368
Attention-deficit disorders	97	462
Autistic disorders	258	428
Significant developmental delay/mental retardation		
Mild grade	207	380
Moderate grade	47	117
Severe and profound grades	19	65
Others		104
Motor impairment		
Clumsiness/motor delay	77	1 124
Cerebral Palsy	66	121
Others	7	22
Visual impairment		
Blind (both eyes)	10	15
Low vision (both eyes)	3	15
Other visual impairment	31	101
Hearing impairment		
Moderately-severe grade or worse (bilateral)	31	69
Other hearing loss	120	375
Psychological difficulties	31	188
Problems in parenting	359	290
Total number of new cases	5 181	7 365

6.3 Views from stakeholders

During the focus group discussion, preschool workers, parents, social workers and health professionals pointed out the difficulties faced by children with developmental problems, their parents, and the preschool workers. They maintained that there was a long delay in the process of identification and diagnosis. One participant summarized the situation as follows:

For special children, usually, those smart mothers might notice quite early, but (they) just notice, and they do not know how to make a diagnosis as to whether they are special, whether there is a special difficulty. Therefore, until they start kindergarten, and (they) take it as social (problems). That is...most parents will say, (they are) naughty, stupid, lazy. Actually, a lot of kindergarten teachers do not have the ability to assess, unless (you) refer them to some...child workers. They do the assessment and then (you) know what it is. However, this process may actually delay helping the child. (Group 6: E38)

Apart from children with various developmental problems, preschool workers, parents and health professionals claimed that there was little provision for gifted children. One parent described her experience as follows:

The report came out and it said that my child had high IQ, but there's no service. I asked everywhere, rang again, asked everywhere, but there's nothing. (Group 9: C107)

Overall, the stakeholders felt that there was inadequate provision for children at either end of the ability range.

7. Summary

For child profile, the data indicates that Hong Kong is doing well in terms of infant and under 5 mortality, as well as immunization rate. Hong Kong children are comparable to those from western countries in terms of motor, cognitive, language and moral development, as well as preschool attendance. However, the data also indicates that obesity, unbalanced diet, lack of physical exercises, oral health, breastfeeding rate, poor social and problem solving skills are some of the areas of concern. As childhood injury is the leading cause of death among preschool children and it is largely preventable, further work in this area should be considered. More effort is still needed in the area of childhood behaviour/emotional problems as they are associated with adolescent conduct problems, delinquency and adult psychotic symptoms. There are considerable human, social and economic costs to the community if these childhood problems are not addressed. Furthermore, stakeholders point out that there is a long process and delay in the assessment and diagnosis of children with developmental problems, creating considerable stress for

the children, their parents and their preschool teachers.

There are also the problems about the lack of consensus on the definition of spirituality and the lack of a common set of local indicators for many of the issues discussed above. This creates difficulties in following the trend of various issues.

Family and parenting profile

8. Family characteristics

According to the 2001 census (Census and Statistics Department, 2002a), there were 209 711 households (10.2% of all domestic households) with one child aged 0 to 4, and 32 763 with at least two children aged 0 to 4 (1.6% of all domestic households). Among households with children aged 0 to 4, there were 118 977 households with only one child. For family composition, in families with children aged 5 or below, 71.3% were nuclear families (at least one parent with one or more never married children), and 13.1% were vertically extended families (related persons of different generations living with the family nucleus in the household).

8.1 Lone parent families and divorce cases

The number of parents a child lives with is strongly linked to the resources available to the child and his/her well-being. Children who live in households with only one parent are more likely to have lower family incomes than are those who live with two parents (biological, step, or adoptive) (Federal Interagency Forum on Child and Family Statistics, 2003). In Hong Kong, there was an increase in the number of children living in lone parent families from 4 419 (1.1%) in 1991 to 8 832 (2.5%) in 2001 (Census and Statistics Department, 2002b), indicating an increasing number of children living in families with more limited resources. The majority are living with their mothers. The breakdowns for children 5 and under (Census and Statistics Department, 2002b) are shown in Table 5 below. The Census and Statistics Department's definition of lone parents is "mothers or fathers who are widowed, divorced or separated, with child(ren) aged under 18 living with them in the same household" (Census and Statistics Department, 2002b, p.3).

For children aged 2 to 5 living in lone parent families, 85.4% were attending preschools (Census and Statistics Department, 2002b). In interpreting these figures, it should be noted that kindergartens start at the age of three (see section 3.5).

The number of divorce decrees has increased rapidly in the past 20 years. In 1981, there were 2 062 divorce cases and in 1991, the number increased to 6 295 divorce cases. The corresponding figures for 2001 and 2002 are 13 425 and 12 943 (The Hong Kong Catholic Marriage Advisory Council, 2003).

Table 5

Dependent children of lone parents by sex of parents

Living with	1991		1996		2001	
	fathers	mothers	fathers	mothers	fathers	mothers
< 2 years old	156	421	254	457	238	1 031
2-5 years old	1 265	2 577	1 552	3 728	1 884	5 679
Total						
< 2 years old		577		711		1 269
2-5 years old		3 842		5 280		7 563

8.2 New immigrant families (legal entrants from the mainland of China)

The results of the 2001 Population Census on “persons from the mainland of China having resided in Hong Kong for less than 7 years” (PMR) are available (Census and Statistics Department, 2002c). In 2001, there were 26 396 domestic households of PMR parents with children aged 5 or below or 28 881 PMR parents (2 149 males and 26 732 females)^v with children aged 5 or below. There were 31 797 children (16 568 boys and 15 229 girls) aged 5 or below with one or both parents being PMRs. They made up 8.95% of the total number of children aged 5 or under. The median monthly domestic household income among these households was \$13,600.00, which is lower than the total median domestic household income of \$18,705.00. However, the latter figure includes all kinds of households, including those with and without children aged 5 or under. Approximately 84.6% of the males and 26.3% of the females were working (either as employees, employers, self-employed workers or unpaid family workers). Though the children in these households are spending their early socialization period in Hong Kong, it is possible that these children’s parents, most likely mothers, are undergoing acculturation in Hong Kong with some resulting acculturation stress. Parents’ stress levels may have some impact on children’s development. If these new PMR families are not familiar with the health and education services, access to adequate health and education services might be affected.

8.3 Ethnic minority families

In the 2001 census (Census and Statistics Department, 2002a), among families with children aged 0 to 4 years, the major non-Chinese ethnic groups included Indians (1 826, 0.6%), British (1 584, 0.5%), Pakistani (1 545, 0.5%), Japanese (1 242, 0.4%), Filipino (1 200, 0.4%), Nepalese (971, 0.3%) and others (8 644, 3%).

^v A domestic household may have more than one PMR.

8.4 Views from stakeholders

During the focus group discussions, stakeholders including preschool workers, social workers, and health professionals were concerned about the development of children from lone parent families and new immigrant families, who were displaying difficulties in various areas. They explained the situation as follows:

Children from real lone parent families, they have no focus when they do things. There are many like this in our (centre)...When we teach them, they really understand, but when (we) ask them to do some things actually, then (they) have difficulties in handling...At home, (the parent) has no time to teach (the child). Also, (the parent) really cannot give them the affection. (Group 1: E17)

Or those who are really ignorant, that is, some new ones (immigrants). They came to Hong Kong but if they have not been able to adapt to the environment, they would feel more helpless. I (the parent) don't know how to bring up (the child), and then, this is followed by behaviour problems. Around 1½ to 2 years old, temper tantrums appear because the child does not know how to express (himself/herself), and they do not understand the child. (Group 12: I6)

Apart from lone parents and new immigrant families, stakeholders also discussed the needs of a special group of parents where the mothers were residing in mainland China. Below is one typical example:

I think this is closely related to the many changes in family structure. For example, we call them “fake lone parents” because basically, the mothers (two-way permit holders) have to go back to mainland China all the time, that is, coming here only periodically. There are some older ones (fathers)...we reckon that there are great differences in parental communication, in expectation towards the child. Therefore, we can see that this is rather helpless as these children have to face lots of changes in their early childhood period, that is, sometimes going back to mainland China to live for a few months, sometimes back here, sometimes with the maternal grandmother, sometimes moving...We all know that this unstable living environment has a great impact on the child. (Group 5: B13)

Not only did service providers recognize that this type of living arrangement was not conducive to child development, they also pointed out that it was very difficult for service providers to provide support to these families. One service provider explained this as follows:

Most of the time the father takes the child here, but the mother is still in mainland China...We tell them to go back and tell the mother to do this and that. Whether the father does pass the information to her is unknown. We can at most talk to them about the pamphlet on development, and then tell them to pass

the message to the family members...Therefore, teaching children is becoming much less adequate. (Group 12: J7)

8.5 Summary

Though there is official statistics on the number of lone parent families with preschool children and new immigrant children, it should be noted that such information is lacking for the so called “fake lone parent” (假單親) families, which are really “de facto lone parent” families. Stakeholders, however, are concerned that these three types of families are experiencing considerable difficulties in bringing up their children.

9. Parental employment

Secure parental employment lowers the incidence of poverty and the associated risks to children. Secure parental employment is also thought to be important to children’s psychological well-being and family functioning as parental unemployment and underemployment could lead to stress and other negative effects on the parents and the family (Federal Interagency Forum on Child and Family Statistics, 2003).

9.1 Paternal employment

According to the 2001 census (Census and Statistics Department, 2002a), in families with children aged 5 or below, 8.0% of the fathers were not working. If we assume that the father is the main breadwinner of the family, this implies that this group of children are likely to be living in families with some financial strain, and possibly the psychological strain associated with parental unemployment.

In 2001, the unemployment rate for persons aged 15 or above was 5.1% and the corresponding figure for 2003/04 (June 2004 to August 2004) is 6.8% (Census and Statistics Department, 2004).

9.2 Families on Comprehensive Social Security Assistance (CSSA)

There was a steady increase in the number of households with at least one member aged below five receiving CSSA since January 2002. The figures rose from 11 370 in January 2002 to 14 183 in December 2002, to 21 905 in July 2004, indicating an increasing number of children living in families with very tight budgets.

9.3 Maternal employment

In terms of working status of mothers, in families with children aged 5 or below, 49.0% of the mothers were not working. This suggests that about 51% of the children are in need of some kind of childcare arrangements. In a recent survey of

MCHC clients by DH (Department of Health, 2003), it was found that families using domestic helpers reported lower parenting stress scores than those using grandparents, or relatives as childcare assistance or those without any assistance. This pattern was fairly consistent across income levels. In an earlier study with 526 parents (three quarters of which were mothers) with children aged 2 to 12 years old (participation rate: 60%), the working parents perceived their children to be more adaptable and felt less restricted in their parental roles than housewives (experience of parental role as restricting their own freedom and frustrating their own attempts to maintain identity) (Kwok & Wong, 2000). In the 2002 Chinese University of Hong Kong study, it was found that maternal employment was associated with higher willingness and ability to participate in parent education, school and community involvement, better family relationship, higher parenting ideology (belief in parent responsibility for supporting children), more home involvement with children, more constraints (personal constraints such as poor temper, external constraints such as insufficient living space), lower frequency of using inappropriate parenting approaches in solving conflicts and fewer child behaviour problems. However, it must be pointed out that maternal employment and use of domestic helpers are likely to be related to family income, maternal education and occupational status and these socio-economic factors were also found to be related to parenting stress (see section 10.1).

9.4 Views from stakeholders

In the focus group discussions, participants pointed out that parents from low socio-economic background did not seem to care much about their children. Two participants described their observations as follows:

The lower class ones have nothing (no demands). You feed them (children) well and that's it. (Group 5: G16)

However, there is another group of parents, who are poor. They cannot even manage their own livelihood, and they basically have no time to look after their children, and just leave them as they are. (Group 15: I109)

Furthermore, preschool workers, social workers, parents, and health professionals commented on the difficulties faced by parents from low socio-economic background in relation to their access to parenting information. One participant explained this as follows:

Can they really read that much written information? For example, there are clinics with lots of parents of lower social class, and they really don't know. How many mothers would go back and read? For example, we have (pamphlets) on CPaP (childcare and parenting) Development, and (we) give them out by piles. (Group 13: D41)

In relation to parental employment, the issue of childcare was discussed by stakeholders from all sectors, especially the issue of domestic helpers and grandparents. A variety of child problems were attributed to these forms of childcare by the focus group participants. One participant explained this as follows:

I think domestic helpers do not have the patience to teach (the child) slowly. The most important thing is that you don't give them trouble. Even for the older people (grandparents), they are very concerned about the relationship and as long as you (grandchild) call (greet) them grandma or grandpa, they will let you (grandchild) do things that they did not allow their own son to do. (Group 7: A40)

Other stakeholders also pointed out the specific language problems associated with the use of domestic helpers. This point can be illustrated by the following quote:

Some domestic helpers use non-fluent Cantonese, plus some semi-correct English. Also,...nowadays, there are more working parents, and so there is less time (to spend) with children. A lot of times, many learning activities are dependent on the help of the domestic helpers. I do not deny that some domestic helpers are very capable, but there are some domestic helpers whose language abilities are not too high, whether English or Chinese, and, it turns out that some children, during this bi-lingual period, they are not actually bi-lingual, ... but they only hear some semi-correct pronunciations. Also, because they lack intensive ... parent attention, they have problems in pronunciation, and it affects their self-expression. (Group 2: M4)

In short, stakeholders were concerned about the parenting problems faced by families of low socio-economic status and the impact of non-parental childcare on children. Stakeholders were concerned about the quality of child minders and were worried about the possible adverse effect of poor quality child minding.

10. Parenting

10.1 Parenting difficulties

Information about parenting difficulties is obtained from several sources, namely, official statistics and survey results.

Official statistics of the CAS (DH) which serves children from birth to 12 shows that there were 359 (6.9% of all new cases) new cases in 2001 and 290 (3.9% of all new cases) new cases in 2002 classified as having problems in parenting. SWD has information on main presenting problems of cases presented to the Family Services Centres (FSCs) and Integrated Family Service Centres (IFSCs) both in SWD and NGOs. The figures provided by SWD are presented in Table 6. It should be noted

that the CAS figures are the final diagnostic categorization whereas the SWD figures are the main presenting problem of the clients when they first approached the services.

These official statistics are the number of clients who actually approach various service providers for service and the clients are not restricted to parents of preschool children.

Table 6
Presenting problems in FSCs and IFSCs

Nature of problem	No. of cases as at Dec 2001 (% against total no. of cases)	No. of cases as at Dec 2002 (% against total no. of cases)	No. of cases as at Dec 2003 (% against total no. of cases)
Parenting difficulty	4 655 (9%)	4 665 (9.1%)	4 333 (8.8%)
Parent-child relationship	1 985 (3.8%)	1 799 (3.5%)	1 696 (3.4%)
Child care arrangement	2 843 (5.5%)	2 713 (5.3%)	2 643 (5.4%)

Source of information: Social Welfare Department

For the prevalence of parenting difficulties in the general community, results from several surveys are available. It should be noted that the surveys are not restricted to parents of preschool children.

In a survey on 224 parents with children under 15 years old, selected randomly by telephone numbers (participation rate: 37%), about 55.2% indicated that they had great or extremely great difficulties in parenting their children (Hong Kong Council of Social Service, 1999). In assessing their performance as parents, 75.9% of the respondents gave themselves a score of 6 or above (possible score range: 1 [poorest] to 10 [best]).

In another survey, through multiple stage sampling of about 1 000 parents of children attending kindergartens or preschools from six regions, it was found that parents reported great or very great stress in relation to their children's academic performance (51.7%), their children's discipline (49.5%) and themselves being a good parent (47.4%). It was also found that lone parents reported a higher stress level than parents in two-parent families (香港小童群益會家庭生活教育組, 2000).

In a recent survey by the DH on MCHC clients (see also section 4), there was a fairly consistent pattern showing that parents with lower education attainment, lower occupational status and lower family income reported higher parenting stress. It was also clear that the availability of social support was associated with lower parenting stress. Parenting stress was also found to be related to marital relationship and child

behaviour problems (Department of Health, 2003). About 31% of the clients scored above the 90th percentile (indicative of parenting difficulties) on the Parenting Stress Index, according to the original norms which was based on an American sample selected through an opportunistic sampling procedure (Abidin, 1990). However, it is uncertain whether these norms are meaningful or applicable to Hong Kong parents.

In a study to validate the Chinese version of the Parental Stress Scale, using a sample of parents attending parent education programmes ($n = 137$) and parents seeking counselling service because of parent-child relationship problems ($n = 120$), it was found that mothers reported higher scores than fathers, and parental stress was higher among those with lower educational levels and lower income (Cheung, 2000). This is consistent with the DH findings (Department of Health, 2003).

Though there are a number of surveys on parenting difficulties, it is not possible to accurately estimate the prevalence of parenting difficulties as different surveys use different instruments, and different sampling methods. Furthermore, valid local norms are not available. Nevertheless, the available information indicates that a considerable number of parents are reporting parenting difficulties and parents with lower socio-economic status are experiencing more difficulties.

10.2 Parenting styles, beliefs and practices

Parenting can be investigated in terms of parenting styles. Authoritative parents set clear rules and standards, encourage socially mature behaviour and respond to the child's individual needs (Bee, 2000). Authoritarian parents are demanding and unresponsive towards their children. They emphasize obedience, order and respect for authority (Bee, 2000). Indulgent parents are tolerant and warm, and they use little punishment (Bee, 2000). Neglectful parents are neglecting or uninvolved with their children (Bee, 2000). It is found that authoritative parenting style is more conducive to the healthy development of children, including academic performance, self-esteem, social responsibility and psychosocial functioning (The Boys' & Girls' Clubs Association of Hong Kong, 1994).

In the Chinese University of Hong Kong (2002) study mentioned in section 4, parents of preschool children used three major methods in dealing with parent-child conflict (in order of likelihood), namely, reasoning, ignoring the conflict, and use of emotion or violence. Use of reasoning is associated with authoritative parenting style and use of emotion or violence is associated with authoritarian parenting style.

In a study involving 180 adolescents and their parents, parents' mean rating of themselves on a 5-point scale (the higher the score, the closer to the specific parenting style) indicative of permissive parenting was 3.60, that for authoritarian parenting was 3.40 and that for authoritative parenting was 4.31. The results indicated that this

sample of parents rated their parenting styles as closest to the authoritative style. The corresponding adolescents' ratings for their parents were 3.46, 3.26 and 4.48 (McBride-Chang & Chang, 1998).

In another study using stratified cluster sampling involving 1 337 students from 16 primary schools and 20 secondary schools, students rated their parents' parenting styles. It was found that 27.7% were rated as authoritative, 15.0% as authoritarian, 13.4% as indulgent and 43.9% as neglectful (The Boys' and Girls' Clubs Association of Hong Kong, 1994). From the above figures, there are still a large percentage of parents engaging in parenting styles which might not be most conducive to the development of their children. Nonetheless, it must be remembered that these surveys were not restricted to parents of preschool children and non-random sampling techniques were used.

For parenting beliefs, in a study on 553 parents contacted outside primary schools and kindergartens, the most common "faulty" beliefs among parents included evaluation of children's worth in terms of academic performance, over protection and an emphasis on children's obedience (張兆球, 2000). The number of "faulty" beliefs was positively related to children's age and the number of children in the family and negatively related to parents' educational level and income.

Another study examined parents' expectation towards their children (Ebbeck, 1996). The sample consisted of 130 parents with children aged 1 to 12 but no information about sampling was provided. The parents were interviewed by research assistants using an interview schedule with 64 questions. The most common expectations could be grouped into three large categories: be healthy and happy, study hard and be well-educated, and be well disciplined. Social skills were not highly rated by this sample of parents.

For parent involvement in home literacy, in the Li and Rao (2000) study, it was found that 75% of the parents did not set a definite time for reading stories to their children. Forty-five percent reported that the duration of each reading session was 15 to 30 minutes. It was also found that 73% of the parents taught their children to read and 52% of the parents taught their children to write Chinese characters at home. There were 59% of the parents who set up reading corners at home; 82.5% of the parents reported that they had more than 30 children's books at home and 42.5% of the parents bought or borrowed Chinese books for their children once per month. However, it must be remembered that these results are based on a small sample of middle class parents.

10.3 Participation in parenting education

In the DH survey (Department of Health, 2003), it was found that about 30% of those surveyed reported no contact with parenting education or service. Participation in parenting education was not related to any socio-economic and demographic factors though fathers and younger parents were less likely to participate. In an earlier telephone survey of 224 Hong Kong parents of children 15 years old or below, it was found that 61.3% of the participants had never attended any parenting activities (Hong Kong Council of Social Service, 1999).

In the 2002 Chinese University of Hong Kong study, among parents with preschool children, parental involvement in parent education (measured as parental involvement in school and community activities, willingness and ability to participate in parent education) was found to be positively associated with parent educational level, family income, home-based parent involvement (parents spending time with children), previous experience with parent education, family relationships (sense of belonging, constructive problem solving, harmonious family environment), parent ideology (belief in parents' responsibility in supporting their children), and irrational parenting approach (use of emotion/violence or ignoring the conflict). One possible explanation about the relationship between parent involvement in parent education and irrational parenting approach is that parents who employed this type of unproductive parenting approach might find their parenting methods ineffective and were therefore more willing to participate in parent education to learn different ways of managing their children. Parental involvement in parent education was also positively associated with parenting constraints (personal constraints such as poor temper, external constraints such as pressure from work), in the sense that parents who were aware of these constraints were more willing to participate. The number of children below 18 was negatively correlated with parents' ability to participate in parent education. Child behaviour problem was not significantly associated with parent involvement in parent education (Chinese University of Hong Kong, 2002).

In terms of access points, participants in the DH survey accessed parenting education mainly through direct services providers to children, such as schools or MCHCs. The most common forms of participation were reading written information or attending one-off talks, rather than attending courses requiring greater commitment. The DH result is consistent with the Hong Kong ECBI validation study (Leung et al., 2003) where parents of children aged 4 to 16 reported that they participated mostly in talks organized by schools or by reading books.

It must be pointed out that some of the parents sampled in the above studies are not parents of preschool children and the ways the questions are phrased in different studies are different.

10.4 Views from stakeholders

In the focus group discussion, parenting was one of the topics discussed in great details by participants. Stakeholders including preschool workers, social workers, parents and health professionals pointed out a paradoxical situation. On the one hand, parents were demanding in terms of their children's learning. On the other hand, they were over protective in terms of children's self-care, and indulgent as well. The demands of the parents were described by one participant as follows:

The children are under fairly great pressure. That is, even when they are little, their parents are demanding a lot, need to learn many things, know many words, and the training method is inappropriate, keep stuffing them. Sometimes the children may not be able to reach that standard, ... and then they are frustrated, leading to many behaviour problems in children. (Group 16: E10)

The parents were not only demanding towards their children, they were also demanding towards preschool workers. One preschool worker explained the situation as follows:

In some middle class crèches, the parents are very demanding. That is, why don't we teachers talk to (the children) in English entirely once they arrive in the morning...There are parents like that. They want you (to use) English. (Group 5: G16)

At the same time, stakeholders from all sectors pointed out that parents tended to be overprotective towards their children. One participant explained the situation as follows:

Hong Kong children are over protective (protected). In many cases, 4 or 5 year olds, tell them to lie down. Then mummy will help them take off their clothes. After examination, they can just stay there, and wait for mum to help them put on their clothes. (Group 16: B38)

A parent participant also explained that she had to go along with her child's wishes in order to soothe the child. She described her experience in the following quote:

That is, when they are whining, (you) have to let them have their ways, to soothe them, then they will listen. That is, if you soothe them and it is in agreement with their wishes, then they will stop crying. (Group 8: B18)

Apart from the above, stakeholders from all sectors pointed out that parents, whether middle class or working class, had little time to spend with their children. One of the participants described the situation as follows:

Sometimes we see that parents put their child...in the nursery. Basically, our care time is very long, from 8 am to 8 pm, but it is still not enough for them. That is, basically, they cannot come and pick the child up at 8 pm and so this

child will be picked up by someone else, (who) will take the child home and look after the child for a while, and then mother will return at 10 pm. (Group 5: B6)

Some of the issues identified by the stakeholders such as high expectation and over protection are consistent with the quantitative information on parenting difficulties and parenting beliefs from various surveys described in sections 10.1 and 10.2.

Finally, parents, preschool workers, academics and health professionals maintained that parents lacked knowledge on child development and parenting skills.

Actually, the parents in fact do not have much knowledge of preschool education, child growth, physical and psychological development. Therefore, sometimes, their expectations are not reasonable. (Group 3: A16)

I think they have some pressure in their hearts. They want to be good parents. On the other hand, they lack the knowledge and skill to be good parents.
(Group 11: B32)

In the opinions of the stakeholders, some of the parenting problems discussed above might be due to the lack of knowledge on child development and parenting skills on the part of the parents.

11. Marital relationship

There are few studies on marital relationship or attitudes towards marriage among parents of preschool children. In the DH community survey (Department of Health, 2003), among parents with one child aged 4 years, 27.1% were classified as having marital problems on the Relationship Quality Index (Norton, 1983). However, the cut-off point is based on western norms only and this result should be interpreted with caution.

In a study involving 738 men (mean age: 46.5 years) and 761 women (mean age: 42.1 years), it was found that males reported higher marital satisfaction than women. However, the participants were not limited to parents with preschool children (Shek, 1995). In the DH survey (Department of Health, 2003), marital relationship quality was found to be positively related to father's education level.

In another study involving 1 501 married adults from middle and lower middle class backgrounds, it was found that marital relationship was positively related to parent-child relationship (Shek, 1996). In the DH survey (Department of Health, 2003), marital relationship quality was found to be negatively related to child behaviour problems.

In a study on attitudes towards marriage among pre-marital couples (284 participants) (participation rate: 55.0%), there was a half-half split among participants in their endorsement of divorce as a solution for distressed marriages (Yeung Chan &

Kwong, 1997). The participants expected companionship, mutuality, gratification of emotional and sexual needs in marriage. The sample was a convenient sample drawn from people enrolling in premarital programmes.

12. Psychological problems, disabilities and chronic diseases

12.1 Psychological problems

Parental mental illness is regarded as one of the major risk factors for the development of child psychopathology. According to the 2000 household survey (Census and Statistics Department, 2001), there were 50 500 people with mental illness (0.7% of the total population). “Mentally ill persons were defined as those who had been diagnosed as being mentally ill under medical assessment tests (including ex-mentally ill) or had been/were being treated by psychiatrists or had received/were receiving some form of rehabilitation services provided for ex-mentally ill persons (such as psychiatric clinics, private psychiatrists, halfway houses and community psychiatric nursing services) at the time of enumeration” (p.12). It was estimated that there were 393 200 children aged 0-5 at the time of the household survey and among them, 3 000 (0.8%) lived together with at least one mentally ill parent. The remaining 390 200 children (99.2%) included (i) those who lived together with their parents but none of their parents were mentally ill; and (ii) those who did not live with their parents (information on whether those parents were mentally ill was not available). In a study on gender differences in mental illness in Hong Kong, it is concluded that women are more vulnerable to depression (Yip, 2003). The above figures provide some information about the prevalence of mental illness in Hong Kong but there is no information on the number of parents with preschool children with specific mental illness(es).

For specific mental illnesses, postnatal depression (PND), one of the commonest forms of psychiatric morbidity of child-bearing, causes considerable psychological distress to the mother and the family. It is understood that the cognitive and emotional development of the infant may also be affected and the adverse effects may persist into late infancy and early childhood (Lee & Chung, 1999; Lee, Yip, Chiu, Leung, & Chung, 2001).

PND affects between 10% to 15% of recently confined women (Lee & Chung, 1999). In Hong Kong, it is believed that about 12% of local women are affected (Lee et al., 1998). In an epidemiological study among postpartum Chinese women in Hong Kong, drawn from a sample of 959 women admitted to the antenatal booking clinic of a university-affiliated public hospital, it was found that at one month postpartum, the prevalence for major and minor depression were 5.5% and 4.7% respectively. The corresponding prevalence at 3 months were 6.1% and 5.1%.

Altogether, 13.5% of the participants were found to be suffering from one or more forms of psychiatric disorder in the first 3 months postpartum (Lee et al., 2001). The Hong Kong prevalence figures are similar to the international ones.

12.2 Disabilities and chronic diseases

Children rely on their parents or caregivers for their physical, social emotional, economic needs and support. It is possible that parenting and care giving maybe adversely affected if the parents are suffering from chronic diseases or some forms of disability. Parents with chronic diseases or disability may be less able to provide adequate care to the children (Australian Institute of Health and Welfare, 2002).

According to the Census and Statistics Department (2001), among parents with one or more children aged 5 or under, there are 7 500 (1.35% of the relevant parent population) with a disability (single disability: 5 400, multiple disabilities: 2 100). There are more males (4 600) than females (2 900). The respective figures for restriction in body movement, seeing difficulty, hearing difficulty, speech difficulty and mental illness are 2 400, 900, 1 800, 400 and 2 600^{vi}.

There are 26 700 (male: 15 400, female: 11 300) (4.8% of the relevant parent population) parents with one or more children aged 5 or under with chronic diseases (Census and Statistics Department, 2001). The respective figures for hypertension, lung and respiratory system diseases, diabetes mellitus, liver diseases, heart diseases, disease of digestive system and kidney diseases are 5 900 (22.1%), 3 000 (11.1%), 2 900 (10.9%), 2 400 (9.0%), 2 100 (7.7%), 2 000 (7.6%) and 1 000 (3.6%)^{vi}.

13. Domestic violence (battered spouses)

Children who have witnessed domestic violence are known to exhibit physical and psychological problems, such as problems with their weight, eating, sleeping, schooling, close and positive friendships, and they may even have suicidal tendencies (UNICEF, 2000). At present, the statistics on battered spouse is captured by the Central Information on Battered Spouses Cases and Sexual Violence Cases. The number of newly reported battered spouse cases has been increasing in the past three years. There were 2 433, 3 034 and 3 298 newly reported cases in 2001, 2002 and 2003 respectively. The recent changes in the socio-economic situation may have weakened family solidarity. This, together with raised public awareness and early help seeking as a result of enhanced publicity measures, may have led to an increase in the number of cases reported. In Hong Kong, the majority of the victims of battered spouses cases are females (around 92%) and the largest number of cases

^{vi} A person may have more than one type of disability or illness

reported is in the age range 35-39. There is an increasing number of battered spouses cases reported but again, it must be pointed out that due to the issue of social stigma and economic concerns, it is likely that domestic violence is under reported. In a survey of 1 132 female respondents randomly selected from the telephone directory (participation rate: 53.4%), it was found that 67.2% reported at least one incident of verbal abuse and 10% reported at least one incident of physical abuse during the survey year. The most frequently reported form of verbal abuse was husbands sulking or refusing to talk to their wives. For physical abuse, the rate of minor and severe violence was 9.8% and 1.4% respectively (Tang, 1999b). Table 7 below shows the number of newly reported cases over the years 1998 to 2001. To have a better understanding of family violence in Hong Kong and to facilitate formulation of prevention and intervention, SWD has commissioned the University of Hong Kong to conduct a two-year study on child abuse and battered spouse in April 2003.

While the issue of domestic violence is receiving increasing attention, the actual prevalence rate is unknown. The present figures are likely to be under estimations due to under reporting associated with social stigma and economic concerns of the victims. The Working Group on Combating Violence (WGCV), convened by the SWD and comprising representatives from different policy bureaux, departments and NGOs, will continue to work closely to map out strategies and approaches for the prevention and handling of spouse battering and sexual violence at the central level.

14. Summary

The lack of valid local norms and the concern about the cultural appropriateness of western norms of parenting issues make it difficult to arrive at any firm conclusions about the prevalence of parenting stress or difficulties experienced by Hong Kong parents. However, both the quantitative and qualitative data suggest that a considerable number of parents are experiencing parenting difficulties. Furthermore, both the quantitative and qualitative data consistently show that socially disadvantaged families, such as families with parents of lower socio-economic status, lone parent families, and new immigrant families are experiencing more parenting stress, holding more “faulty” parenting beliefs, and experiencing considerable problems in child rearing; which might impact on their children’s development. The quantitative and qualitative data also suggest that a considerable percentage of parents are engaging in parenting styles which might not be conducive to the development of their children. In the opinions of the stakeholders, many parents have very high expectations on their children’s learning and they often over protect their children in the area of self-care. At the same time, stakeholders point out that a common

phenomenon among parents from all social backgrounds is that parents have to work long hours and they have little time to spend with their children. The impact of postnatal depression on the mother and child development is also of concern.

Table 7

Number of battered persons by sex and age

Age	1998			1999			2000			2001		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
≤24	1	44	45	2	83	85	7	109	116	5	90	95
25-29	3	125	128	9	209	218	12	256	268	10	211	221
30-34	2	202	204	12	306	318	21	420	441	11	489	500
35-39	9	262	271	16	416	432	22	533	555	28	548	576
40-44	10	175	185	24	263	287	36	395	431	35	420	455
≥45	14	156	170	58	280	338	73	435	508	86	490	576
Not recorded	0	6	6	0	1	1	0	2	2	4	6	10
Total	39 (3.9%)	970 (96.1%)	1 009 (100%)	121 (7.2%)	1 558 (92.8%)	1 679 (100%)	171 (7.4%)	2 150 (92.6%)	2 321 (100%)	179 (7.4%)	2 254 (92.6%)	2 433 (100%)

Source: Social Welfare Department

Summary and conclusion

15. Child profile

In terms of physical health, the Hong Kong situation is among the top in the world in areas such as infant mortality, under 5 mortality, and immunization rate. The data on motor, cognitive, language and moral development, as well as preschool attendance also suggest that Hong Kong children are comparable to their peers in western societies.

Nevertheless, there are concerns about obesity, unbalanced diet, child abuse and low physical activity level in Hong Kong children. The breastfeeding rate in Hong Kong is still low compared to other industrialized countries. As childhood injury is the leading cause of death among preschool children and it is largely preventable, further work in this area should be considered. There is also room for improvement in terms of oral health. Child behaviour problem is another area for further work because of the linkage between child behaviour problems, adolescent delinquency and adult psychiatric problems. Furthermore, stakeholders from all sectors unanimously point out that children lack social skills such as sharing, and problem solving. Stakeholders also maintain that more attention should be given to spirituality though there is no consensus on the definition of spirituality. Stakeholders note that there is a long process and delay in the assessment and diagnosis of children with developmental problems. Developmental delay and language problems are the major problems diagnosed.

16. Family and parenting profile

For parenting issues, both the quantitative and qualitative information indicate that parents are experiencing considerable stress. The major parenting issues are high parental expectations regarding academic performance and over protection, though it is recognized by stakeholders that there are parents who are giving their children minimal attention. There is also the issue about the impact of postnatal depression on the family. Furthermore, there is the stakeholders' concern that parents could only spend very little time with their children. Effective measures to deal with these parenting issues would need to be investigated.

The quantitative and qualitative data identify a few categories of families that are experiencing more problems in parenting, such as parents from low socio-economic backgrounds, lone parent families, and new immigrant families. The parenting difficulties in these families are thought to be affecting their children's development. More information about the specific needs of these families is needed to guide the development of effective programmes.

The issue of childcare and domestic helpers has been mentioned by many frontline workers. The effect of different types of non-parental childcare on the development of children needs to be further investigated. Most overseas research in this area is on the use of childcare centres, and in most cases, it is found that with quality child care, children's development is not adversely affected. (Bee, 2000; Erel, Oberman, & Yirmiya, 2000; NICHD Early Child Care Research Network, 1997; Scarr, 1998; Zortich, Roberts, & Oakley, 2003). However, there is little research on the use of domestic helpers or relatives as childcare, and this is an area requiring further local research. Locally, there is little or no government control about the quality of private child minders, though there are clear guidelines for the operation of child care centres and qualifications of child care centre staff (see chapter 4, section 10).

17. Indicators

For many of the above issues, including physical activity level, nutrition, and obesity status, social and problem solving skills, cognitive and language skills, spirituality, parenting stress and difficulties, there is no clear information on the size of the problem. The available information is based on many different individual studies of various scales, using different sampling frames and different measurement tools.

Some of the major obstacles to the establishment of prevalence rates are lack of valid local indicators and measures, lack of local norms and lack of a surveillance system for gathering information systematically from all sources. In countries such as Australia, Canada, and the United States, there is a set of indicators of child well-being and related measures developed by a panel of experts in the area. There are also mechanisms for the data to be collected regularly (see Appendix 4).

In Hong Kong, there is an urgent need for the development of valid local indicators and measures, as well as a system for regular collection of data, to monitor the well-being of preschool children and their families so as to provide information for service planning and provision.

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Chapter 4

Current Programmes

Having described the well-being of Hong Kong preschool children, this chapter focuses on the currently available programmes for preschool children and their families. In this instance, the term “programme” is used in a very generic sense, referring to any activity or service that is provided to preschool children and their families (McCain & Mustard, 1999).

The main sectors responsible for service provision to preschool children and their families are the health sector, the education sector and the social welfare sector. In the sections below, the programmes provided by each sector are presented separately. It must be pointed out that the programmes described here are broad major categories and the exact nature and characteristic of the service provision may vary between various individual providers. Names of individual providers from non-governmental sectors or private sectors will not be mentioned here and this chapter should not be regarded as a service directory.

Health sector

Programmes for preschool children and their families are mainly offered through the FHS and CAS, as well as medical care services in the hospitals and the community.

1. Department of Health Family Health Service programmes

The service is provided through a network of MCHCs which cover over 90% of all newborns in Hong Kong, and the target clients are children 0 to 5 and their parents and caregivers. To meet the current needs of parents and children, the FHS has revamped the “Integrated Child Health and Development Programme”, incorporating parenting education as a major health promotion and disease prevention component. The whole revamping process would take a period of about 5 to 6 years starting from the year 2000 and the programme is expected to be fully implemented by the year 2006. The Integrated Child Health and Development Programme comprises 3 components designed to meet the developmental needs of preschool children in the physical, cognitive and social emotional domains in a co-ordinated way. The three components are (i) parenting programme, (ii) immunization programme and (iii) health and developmental surveillance programme.

1.1 The parenting programme

The programme aims to equip parents of all children attending MCHCs with the necessary knowledge and skills to bring up healthy and well-adjusted children.

The objectives of the parenting programme are to increase parents' competence in managing childcare and developmental issues as well as common behaviour problems; reduce parents' use of coercive and punitive methods in disciplining children; facilitate parent-child relationship and reduce parenting stress associated with raising children. The programme consists of two components. The universal parenting programme is for expectant parents and parents of all children (with focus on 0-3 years) attending MCHCs. They will receive anticipatory guidance on child development, childcare (e.g. nutrition, home safety, oral health etc.) and parenting issues (e.g. attachment, temperament, limit setting and behaviour management) which are appropriate to the ages of their children. The intensive parenting programme (Positive Parenting Programme) is for parents of children with early signs of behaviour problems or parents who encounter difficulties with parenting. The Positive Parenting Programme (Triple P) is a parenting programme adapted from Australia and has been evaluated to be effective in the local context (Leung, Sanders, Leung, Mak, & Lau, 2003). The programme has been implemented in phases since September 2002. A pilot project, in collaboration with SWD, incorporating a support group component with the Triple P is being trialled and evaluated.

A comprehensive educational kit has been produced for pregnant women and lactating mothers in 2002, to provide them with sufficient information to make an informed choice and full support to breastfeed their babies. It should be noted that the promotion of breastfeeding is a collaboration between the DH, HA and Baby Friendly Hospital Initiative Hong Kong Association.

1.2 Immunization programme

Immunization against 9 infectious diseases is provided at intervals as recommended by the Advisory Committee on Infectious Diseases, which meets regularly to review and update the recommendations and guidelines. The currently recommended schedule for preschool children is shown in Table 8:

Table 8

Immunization schedule

Age	Immunization recommended
New born	B.C.G. Vaccine
	Polio Type I
	Hepatitis B Vaccine - First dose
1 month	Hepatitis B Vaccine - Second dose
2-4 months	DPT Vaccine (Diphtheria, Pertussis & Tetanus) - First Dose
	Polio Trivalent - First Dose
3-5 months	DPT Vaccine (Diphtheria, Pertussis & Tetanus) - Second Dose
4-6 months	DPT Vaccine (Diphtheria, Pertussis & Tetanus) - Third Dose
	Polio Trivalent - Second Dose
6 months	Hepatitis B Vaccine - Third Dose
1 year	MMR Vaccine (Measles, Mumps & Rubella) - First Dose
1 ½ year	DPT Vaccine (Diphtheria, Pertussis & Tetanus) - Booster Dose
	Polio Trivalent - Booster Dose

1.3 Health and developmental surveillance programme

Health care professionals at the MCHCs work in partnership with parents/caregivers in the continual monitoring of health and development of the child through (i) newborn examination; (ii) growth monitoring; (iii) developmental surveillance; (iv) hearing screening; and (v) vision screening.

- Newborn (NB) examination – newborn examination is routinely carried out in MCHCs to identify any congenital abnormalities (e.g. congenital heart disease) or other significant health conditions such as neonatal jaundice (NNJ) that require further medical attention. Apart from physical problems, this is a good opportunity to discuss with parents matters related to childcare, feeding and parenting, and to give them anticipatory guidance, as well as to identify any family and social problems that require attention.
- Growth monitoring – the monitoring involves measuring of the length/height, weight and head circumference of the child at certain ages, aiming to detect growth abnormalities early; to let parents know the progress of their children’s physical growth and to address their concern. Growth parameters will also be measured if at any time there is concern or suspicion about any growth problems.
- Developmental surveillance programme – through anticipatory guidance, parents are empowered to monitor their child’s development. At various stages, health professionals obtain relevant developmental history from parents/caregivers, identify parental concerns, perform observation of children’s development, and

provide parents with the appropriate advice. Children identified to have significant developmental problem after assessment by doctors will be referred to the child assessment centres (CACs) for more comprehensive assessment and rehabilitation.

- Hearing screening programme – the objective of the screening programme is to identify bilateral sensori-neural hearing impairment of moderate to profound grade in early infancy for better outcome in language development. Babies are tested by the Automated Otoacoustic (AOAE) test, preferably before two months old. Babies who fail the screening are referred for diagnostic assessment and management.
- Vision screening programme – the main aim of the vision screening test between 3 and 5 years is for early identification and referral of amblyopia and associated conditions. Currently, the LogMar Crowded test (Keeler) is used for visual screening in 4-year-old children, whereas the uncrowded chart is used for younger children.

1.4 Antenatal service

FHS provides free (for Eligible Persons) antenatal service to all pregnant women in Hong Kong under the shared-care system with the Obstetrics and Gynaecology Departments in HA hospitals. Routine blood screening for all pregnant women aims to identify those with problems requiring prompt management, e.g. HIV screening to prevent vertical transmission of AIDS. Comprehensive health education activities consisting of workshops, individual counselling, distribution of information leaflets and audio-visual materials on nutritional advice, parenting, baby feeding, anticipated changes in relationship with spouse and mood changes during pregnancy are given to all pregnant women and their spouses during routine follow-ups. Since December 2002, a referral system between FHS, FSCs/IFSCs and the Medical Social Workers of the HA has been established for pregnant women at psychosocial risk including unmarried mothers and those with substance abuse. New mothers found to have mood problems will receive counselling by doctors in FHS.

1.5 Postnatal depression

Medical and nursing staff of MCHCs are trained to identify risk factors for PND during the antenatal period so that these are dealt with as appropriate. Health professionals conduct clinical assessment on all mothers at the 6-week postnatal visit and during other child health sessions where mothers are present. Clients are encouraged to discuss their feelings with MCHC staff and referral to specialists can be arranged if deemed necessary.

All pregnant women and their family members are encouraged to participate in educational activities (see section 1.4) to enhance social support to the mother. When problems are identified, MCHC medical and nursing staff will offer individual counselling and relevant support groups to the mothers. Referrals to social services are arranged if necessary.

2. Community child health services

There are other NGO or private hospital operated community child health services which are largely similar to MCHC services. The services are delivered through community health centres, hospital child health centres or schools.

The target clients are preschool children, and the service aims to help prevent disease in children and to promote healthy development in physical and cognitive areas, and to provide health consultation for parents and teachers. The services are offered through individual interviews with nurses or paediatric consultations, and include guidance on childcare, immunization, physical and oral examination, developmental (intelligence) testing, hearing and vision screening, toy and resource centre, telephone consultation and talks on various topics.ⁱ

3. Private practitioners

Private practitioners also provide health care services to children in general. The services include health surveillance, health education, immunization, medical examination and treatment, and referral to appropriate services where necessary. There is close partnership with the public sector in rehabilitation and acute crisis management.

4. Department of Health Child Assessment Service programmes (Department of Health, 2002a, 2002b)

The CAS provides services for children from birth to 12 years old with developmental problems. It aims at promoting optimal physical, mental and emotional health of children as well as enabling them to achieve their potentials. The programmes are provided through the seven CACs. Team members comprise paediatricians, health nurses, clinical psychologists, social workers, audiologists, speech therapists, physiotherapists, occupational therapists, optometrists and orthoptists. They work together to provide comprehensive physical, psychological and social assessment for children with developmental anomalies. The services include (i) assessment for diagnosis and functional evaluation of abilities and disabilities; (ii) therapy and training for selected children; (iii) developmental

ⁱ Service details may vary depending on the providers.

guidance, counselling and support for parents; and (iv) referral of children and parents to appropriate agencies for medical, developmental, educational and social services.

5. Hospitals

Hospitals, both public and private, also offer a wide range of in-patient and out-patient health services to preschool children. In the year 2002/2003, there were a total of 1 214 paediatrics beds in 17 HA hospitals and 279 paediatrics beds in 10 private hospitals. The corresponding figures for neonatology beds were 453 (10 HA hospitals) and 79 (4 private hospitals) respectively (Hospital Authority, 2004). In addition, there were also public and private hospitals offering child and adolescent psychiatric in-patient and specialist out-patient services, occupational therapy, physiotherapy and speech therapy services.

Education sector

One of the services to preschool children by the education sector is in the area of pre-primary education. However, in Hong Kong, pre-primary education is provided by both the education sector (kindergartens) and social service sector (day nurseries). The two kinds of institutions under the two different sectors are governed by different ordinances and regulated by different government departments (EMB and SWD). To avoid duplication, all issues related to pre-primary education is reported in this section whereas child care issues are discussed under the section on the social service sector.

6. Pre-primary education (Education and Manpower Bureau, 2002)

6.1 Service provision and operation

The target clients are children aged 2 to 6 years old. Pre-primary education is provided by two separate types of institutions: kindergartens which are registered with the EMB, and day nurseries, which are registered with the SWD (Chan & Chan, 2003).

Kindergartens provide services for children from 3 to 6 years old. At present, most of the kindergartens operate on half-day basis offering upper, lower kindergarten classes and nursery classes. Full-day upper and lower kindergarten classes are only operated in some kindergartens. All kindergartens in Hong Kong are privately run and they can be categorised as non-profit-making kindergartens and private independent kindergartens depending on their sponsoring organisations which can be either voluntary agencies or private enterprises. All kindergartens are registered under the Education Ordinance.

Day nurseries cater for children aged 2 to 6. Day nurseries provide full-day and half-day services, and most of the nurseries provide full-day services. The majority of the day nurseries receive 5% subsidy from the Government, while others are either operated by non-profit-making organizations or private operators. All day nurseries are registered under the Child Care Services Ordinance.

6.2 Curriculum and inspection

Inspectors from the EMB visit the kindergartens regularly to give advice to principals and teachers on curriculum, teaching approaches and school administration. The “Manual of Kindergarten Practice”, issued by the EMB, provides prospective school operators with the necessary information regarding statutory requirements and recommendations for the operation of kindergartens. Day nurseries are subject to the inspection and control of the Child Care Centres Advisory Inspectorate of the SWD. The “Guide to the Pre-primary Curriculum” (Education Department, 1996) was issued to all kindergartens and day nurseries for reference in curriculum planning.

6.3 Teacher: pupil ratio

In order to allow teachers more time to give children individual attention, from the 2001/2002 school year, the then Education Department (ED) started to improve the teacher to pupil ratio. The ratio for nursery classes was 1:15 in 1996/1997. In recent years, there has been an improvement in teacher to pupil ratio in kindergartens (1: 11.8 in 2000/2001; 1:11.6 in 2001/2002). For day nurseries, the ratio for children above 2 years old is 1:14.

6.4 Staff qualifications and training

In terms of staff qualifications, the minimum academic entry qualification for kindergarten teachers is five passes, including both Chinese and English, in the Hong Kong Certificate of Education Examination. Since September 2000, kindergartens are required to have 60% qualified kindergarten teachers. By the 2004/2005 school year, all kindergartens are required to employ 100% qualified kindergarten teachers. Kindergarten principals are required by present regulations to acquire the status of ‘Qualified Kindergarten Teacher’ (QKT) or its equivalent. By 2002 school year, all newly appointed kindergarten principals are required to have completed the Certificate in Kindergarten Education Course, or its equivalent. Day nurseries are operated by trained child care staff, who have to fulfil the qualifications required for child care supervisors or child care workers recognized by the SWD (see paragraph below).

For training, at present, four local training institutions, including the Hong Kong Institute of Education, Hong Kong Polytechnic University, Hong Kong Baptist University and the Hong Kong Institute of Vocational Education (Lee Wai Lee), offer different modes of basic professional training course for practitioners in the field to be registered as qualified kindergarten teachers and child care workers. These training courses are recognised both by the EMB and SWD. A list of the recognized courses can be found in Appendix 3.

7. Integrated programme for mildly disabled children in kindergartens

The target children are those mildly disabled aged three to six. The objective is to help mildly disabled children develop their potential and social skills alongside other children. To achieve this objective, the EMB offers supporting services to kindergartens providing integrated programmes. Kindergartens joining the integrated programme should set aside six places for mildly disabled children. In return, they can receive subsidy for the employment of an additional trained remedial teacher whose salary and provident fund are to be reimbursed by the EMB.

8. Parent-teacher associations (教育統籌局, 2002)

Many of the kindergartens have set up parent-teacher associations. The parent-teacher associations organize different activities including parenting education programmes and other relevant educational activities for parents and children. The members of parent-teacher associations are parents and teachers of the respective kindergartens/schools but students could also benefit potentially from the activities. In the 2002/2003 school year, there are 194 kindergartens (25%) which have set up parent-teacher associations (Education and Manpower Bureau, 2003a).

The objectives of the parent-teacher associations are: (i) to promote home-school co-operation, and to build up good partnership; (ii) to provide an optimal environment for the development of students through home-school co-operation; and (iii) to make the best use of parents' potential to help develop school policy, through giving parents the opportunity to express their opinions about school policy and to discuss educational issues with teachers.

9. Parent Education Initiative

In his 2000 policy address, the Chief Executive has allocated funding for two years to promote and to develop parent education. The initiative is a collaboration among three departments, viz., ED, DH and SWD, and NGOs. In 2001, the Parent Education Implementation Team was formed, under the then ED, to implement the initiative. The main tasks of the team include (i) development of parent education

resource materials including pamphlets and parent education manuals; (ii) funding kindergartens, schools, parent-teacher associations and NGOs to organize parent education activities; (iii) publicity to promote public awareness of parent education through various activities, including roadshows and radio programmes; and (iv) training of parent education organizers

During the two-year period of the parent education funding programme, 432 applications from pre-primary institutions (out of a total of 464 applications) have been funded. There were also 16 applications from kindergarten parent-teacher associations (out of a total of 19) funded.

Social service sector

The social service sector includes the SWD and the various subvented and non-subvented NGOs. They offer a variety of services, including (i) services specific or available to preschool children such as child care service, services for special needs children, residential service; (ii) services for families or the community in general such as FSCs/IFSCs, family life education units; and (iii) other support services of a more specific nature or for specific target groups. Finally, the work of parents' self-help groups, which might be under the auspice of NGOs or registered as non-profit-making organizations, is also included in this section.

10. Child care service (Social Welfare Department, 2003a)

The target clients are children under the age of 6 years. The service aims to support and strengthen the family and to enhance the physical, intellectual, language, social and emotional development of children under the age of 6 years. The service is provided through child care centres which are subject to the registration, inspection and control provided under the Child Care Services Ordinance and Regulations, which is enforced by the Child Care Centres Advisory Inspectorate of the SWD. The majority of the child care centres receive 5% subsidy from the Government, while others are either operated by non-profit-making organizations or private operators. There are different types of child care services:

- Day Crèche (育嬰園) - provides care services to children below the age of 2
- Day Nursery (幼兒園) - provides edu-care services and looks after the developmental needs of children aged between 2 and 6
- Mixed Child Care Centre (混合育嬰幼兒園) - provides care and education services to children below the age of 6
- Occasional Child Care Service (暫託幼兒服務) - provides full day/half day/2-hour session in some child care centres for children whose carers are

unable to take care of them occasionally due to various commitments or sudden engagements

- Extended Hours Service (延長時間服務) - provided in some child care centres to meet the social needs of families and working parents who need longer hours of child care assistance

The office hours for child care centres (including occasional child care service) are from 8:00 a.m. to 6:00 p.m. on Mondays to Fridays and from 8:00 a.m. to 1:00 p.m. on Saturdays. The office hours for extended hours service are mostly from 6:00 p.m. to 8:00 p.m. on Mondays to Fridays and from 1:00 p.m. to 3:00 p.m. on Saturdays. Parents may apply for child care services at their preferred child care centres directly during office hours.

According to the Child Care Services Ordinance and Regulations, the child/worker ratio for children under 2 years old is 1:8 and the ratio for children above 2 years old is 1:14. Child care centres are operated by trained child care staff, who have to fulfil the qualifications required for child care supervisors or child care workers recognized by the SWD (see section 6.4).

11. Residential services for children

Residential child care services are provided for children under the age of 18 who cannot be adequately cared for by their families because of various reasons such as behaviour, emotional or relationship problems, or family crises arising from illness, death and desertion. Referral to the service is made by helping professions responsible for the case through the respective central referral system. There are two types of services, non-institutional care (foster care for children under 18 years of age; emergency foster care for children under 18 years of age and small group homes for children from 4 to 18 years of age) and institutional care (residential crèches for babies under 2 years of age; residential nurseries for children aged from 2 to under 6, residential home for children aged 6 to 18, and children's reception centres for children aged under 12 years of age [children over 12 will be considered on individual case merit]).

12. Day training services for preschool children with disabilities (Social Welfare Department, 2000, 2003b)

There are a number of services for preschool children with disabilities, including early education and training centres (EETC), integrated programmes (IP) in child care centres and special child care centres (SCCC). Referrals can be made by social workers or staff of rehabilitation service units to the CRSRehab of the SWD. All staff members have relevant qualifications in either child care supervisors/

kindergarten principals or child care workers/qualified kindergarten teachers recognized by the SWD and the EMB, social work, physiotherapy, speech therapy and occupational therapy. Special Child Care Workers (SCCWs) have to attend a special training course in addition to the basic course for child care.

The service figures for 2001/2002 and 2002/2003 are listed below:

Table 9

Service figures for day training services for children with disabilities

	2001/2002		2002/2003		Current waiting list		
	Centres	Children	Centres	Children	0-2	2-6	Total
EETC	22	1681	23	1767	211 (78)*	602 (683)*	813 (761)*
IP	284	1631	284	1724	43	775	818
SCCC	25	1259	26	1315	105	404	509

* children who are on the waiting list for EETC and other forms of placement.

13. Residential service for preschool children with disabilities

Residential service for preschool children with disability is provided through residential SCCCs which form part of a range of preschool services for disabled children as a continuum of day training service. These centres provide a coordinated approach of residential care and training to disabled children. The target clients are children whose disability is so severe or complex that warrants intensive and continuous care and therapy and disabled children who are homeless, abandoned, with adverse home or family environment and without an alternative placement. Referrals for service may be made by medical social services units or FSCs/IFSCs or via them by MCHCs, CACs, general practitioners and preschool rehabilitation centres.

At present, there are 5 residential special child care centres catering for 106 and 108 children in 2001/2002 and 2002/2003 respectively. There are 19 children on the current waiting list (March 2004).

14. Family services centres/integrated family service centres (Social Welfare Department, internal communication)

There is an extensive network of FSCs / IFSCs operated by SWD and NGOs over the territory providing counselling and tangible assistance to the needy. The objectives are to empower and support individuals or families, enabling them to cope effectively with personal and family problems, and prevent such problems from arising. In 2004/2005, all FSCs will be transformed to become IFSCs by phases

through pooling of existing resources.

14.1 Family services centres

Family casework is offered through:

- Counselling service - to help individuals and families handle problems such as their emotions, behaviour and family relationship.
- Referral service – referrals for supportive services such as community support service, clinical psychological service, residential care and rehabilitation service etc. will be made as required.
- Statutory service - statutory supervision will be provided by SWD FSC for children under 18 (or 21 for Wards of Director of Social Welfare) who are in need of care or protection.

14.2 Integrated family service centres

IFSC is a brand new service delivery model for individuals and families. It comprises three major components, namely, family resource unit, family support unit and family counselling unit which provides a continuum of preventive, supportive and remedial services to strengthen families. Apart from providing counselling and referral service for families or individuals in need, other core services provided by IFSCs include family life education, parent-child activities, enquiry service, volunteer training, outreaching service, developmental groups, mutual support groups, and therapeutic groups etc. In 2004/2005, SWD and NGOs will re-engineer their FSCs and IFSCs by phases. There will be a total of 61 IFSCs through out the territory upon completion of the re-engineering exercise.

15. Family life education

Family life education (FLE) is a form of community education, which is preventive and developmental in nature. It aims to promote to the public the importance of family life and how it can be sustained through a wide range of educational and promotional programmes such as seminars, family camps, group activities and exhibitions. The main target clients include couples-to-be, parents-to-be, married couples, parents and adolescents. Many FLE programmes are relevant to parents with preschool children.

FLE units are operated by NGOs and they usually operate in collaboration with other community services to provide a continuum of services for clients. The main areas include marriage preparation, antenatal preparation, marital relationship, adolescence growth and development, and parenting.

In pursuance of the recommendation of the Report on the Review of Family

Services in Hong Kong, FLE service will be integrated into the community-based services e.g. IFSCs, Integrated Children and Youth Service Centres, etc. in the long run. In the IFSC re-engineering exercise, a proportion of the FLE resources will be pooled to form IFSCs.

16. Family violence

All along, the government adopts a three-pronged approach to provide a variety of preventive, supportive and specialized services for prevention and handling of family violence. These services include public education, hotline, child care assistances, support/mutual help groups, counselling, clinical psychological service, crisis intervention, emergency outreaching, time-out facility, refuge centre etc. The Family and Child Protective Services Units of SWD are specialized units serving families with the problems of child abuse, spouse battering and child custody disputes.

17. Other support services

Apart from the above, there are other support services which might be relevant to preschool children or families with preschool children. The services include (i) Adoption service; (ii) Hotline service; (iii) Family crisis support centre; (iv) Clinical psychological service; (v) Occasional child care service for disabled children; (vi) Special provision programme for autistic children in special child care centre; (vii) District-based speech therapy teams etc.

18. Parents' self-help groups

There are various parents' self-help groups formed by parents with various backgrounds. Many of these self-help groups are formed by parents of children with disabilities. Some of these are registered as non-profit making organizations or are independent organizations and some of them are linked to NGOs.

Membership varies depending on the nature of the self-help group. For self-help groups formed by parents of children with disabilities, the members are usually parents with children with disabilities but other people who are interested in the activities of the associations may also join.

The objectives vary, depending on the group, but normally, they may include provision of mutual support and information sharing among parents; public education; and advocacy for better service provision. The mode and content of service vary but may include resource libraries, training for children, talks for parents, counselling for parents, public education, social and recreational activities, advocacy and caring service to members or the public. In many cases, the work of the self-help groups is

shared by members of the group.

Harmonization of pre-primary services (Education and Manpower Bureau, 2003b)

As mentioned in section 6, pre-primary education is provided through kindergartens which are under the Education Ordinance and day nurseries which are under the Child Care Services Ordinance. As such, kindergartens and day nurseries have different management planning, modes of service and funding regulations. This has led to disparities in the delivery of service and financial assistance to children. It has also created inconvenience and confusion to operators and parents. As day nurseries and kindergartens are providing similar services to a similar target group, it is suggested that they should be subject to similar requirements, registered under the same ordinance and monitored by one single authority.

A Working Party on Harmonization of Pre-primary Services is set up with representatives from SWD, the Health and Welfare Bureau and the EMB to examine the issue of unification of kindergartens and child care centres which are currently monitored by EMB and SWD respectively. Following the public consultation in May 2002, the Working Party modified the Harmonization proposal and reported the progress to Legislative Council Panel on Education. A special team jointly set up by EMB and SWD has been working on the detail arrangement. Major measures of harmonization are as follows:

- Kindergartens which are more edu-care in nature, will be provided for children aged between 3 and 6 and regulated under the Education Ordinance. Child care centres which are care-oriented will be provided for children aged below 3 and regulated under the Child Care Services Ordinance.
- The minimum ratio of teacher/ child care worker to children aged 2 to 6 should be 1:15. The minimum ratio for children aged 0 to 2 should remain at 1:8.
- To provide one-stop service to the co-located kindergartens and child care centres, a joint office will be set up by the EMB with staff from EMB and SWD.
- A single financial assistance scheme for parents and subsidy scheme for operators will be applied to all kindergartens and child care centres.

Views from stakeholders

19. Concerns about current services

19.1 Health sector services

Most of the participants were satisfied with the MCHC immunization programme and hospital services, as mentioned in chapter 3. However, preschool teachers, social workers, parents and health professionals pointed out that there was a

problem with the use of MCHC service after the age of 2 and this also created problems for the early identification of developmental problems such as language delays. Two participants explained the issues as follows:

The 0 to 3 year-old are taken care of by you Department of Health, but ... the preschool (age range) should go to the age of 6. For example, I said before that there's nobody looking after the 3, 4, or 5 year-olds. However...there are things which develop after the age of 3 but you Department of Health are not doing anything. You leave the parents (alone) who do not know what their children's developmental problems are. (Group 6: B40)

They come back for injections, come back to see us once more at 1½ years old, and then they disappear. (They) may not turn up for the second PE (physical examination scheduled at 2 years). In many cases, this gap in between is the time when there are problems with language delay. We cannot detect this in a lot of cases because parents feel that I am not coming back. Nobody is telling me that there is a problem. There is no proper way to give them (parents) information. By the time (parents) come back, the child is 3 years old and is still like a parrot. What? How? That is, they just repeat what you say, like that, and this is bad. (Group 12: F33)

In short, according to the stakeholders, good services were provided to children 0 to 2 by MCHCs, but they felt that there was a gap in the service for children aged 2 or above. This gap in service could potentially result in difficulties in early identification and intervention of developmental problems. This issue about early identification and intervention of developmental problems echoes the difficulties faced by families with children with developmental problems described in chapter 3.

19.2 Education sector services

The participants were very concerned about the present education system and its emphasis on academic skills. They pointed out that this was not only the problem with preschool education, but the problem with the education system as a whole. This view can be illustrated by the following quotes:

I think that the preschool children in Hong Kong are the only kids in the world that need to do homework. (Group 11: E66)

Now, there are many kindergartens which put a lot of emphasis on academic (skills), too much, such as asking the children to write, and also, the teachers' demands directly affect the parents' demand. Therefore, by three years old, by (pre) school entry, the parents are very anxious (about) homework, demanding (the child) to participate in this and to learn that. Actually, I think ...this involves the whole Hong Kong education system. This is not good for

children's development. (Group 13: C70)

Furthermore, preschool workers, social workers, parents and health professionals felt that there was not enough moral and civic education in the curriculum. One participant explained this point as follows:

Nowadays (schools) put too much emphasis on knowledge, that is, not much on ethics and family relationship. There is not much teaching in these areas, that is, too much emphasis on knowledge. (Group 9: F68)

In short, though it is stated by the EMB that the aim of pre-primary education is to provide children with a relaxing and pleasurable learning environment to promote a balanced development in different aspects (Education and Manpower Bureau, 2002), participants felt that this was not happening in reality. They were extremely concerned about the over-emphasis on academic skills in pre-primary education.

Furthermore, preschool workers, social workers, academics and health professionals maintained that the government was not paying enough attention to early childhood education, in terms of resource allocation and policy. They were very concerned about the lack of government involvement and the fact that kindergartens were privately funded. They explained their concerns as follows:

Because there is no money, and the economy is bad, so there is very little resource which focuses on early childhood education. (Group 4: D45)

I think another issue is the government's policy about the kindergartens, and one of the unique things here in Hong Kong, in comparison with other countries, is that (it's) a commercial enterprise...The fact (is) that the government has a very hands-off view of the early childhood education. (Group 11: I65)

The welfare and education and development (services) are really lacking. If you say the Education and Manpower Bureau feels that 0-3, 3-6 is none of its business, this is impossible. Early education is not education?! They (Education and Manpower Bureau) say that it's not education. Then I don't know what it is! This is very ridiculous. (Group 14: K35)

Participants strongly felt that there should be a government department taking up the prime responsibility of early childhood education. There should be more government leadership and resource allocation.

In addition, parents, academics and health professionals pointed out the issue about the training and academic qualifications of preschool workers. They felt that it was important that preschool workers should be well-trained, well-qualified and well-paid. These views can be illustrated by the following quotes:

Now all the research is saying that preschool education is more and more important. Not to say 6 years old, but even before the age of 3, lots of things have been determined. However, even now we are not funding preschool

education. In fact, (we) should get the best teachers, the university graduates to teach (the children). (Group 7: A84)

Everyone is saying whether preschool educators need education. Do we need to make suggestions to the government to do something? At present, the reason is that it (qualification of preschool workers) is proportional to your salary. A lot of times, Hong Kong people feel that preschool workers are not that important, and people running the preschools need to look at the cost, and so you get what you pay for. I think it (qualification of preschool teachers) is proportional to the salary. (Group 14: G55)

Though participants felt that it was important for preschool workers to be well paid and well trained, they realized that kindergartens were private enterprises, and operators of kindergartens were hesitant to pay for the best teachers as this would mean increased running costs. This resulted in difficulties in attracting well-qualified teachers.

In addition, teacher/child ratio was another issue, which was probably related to the cost as well. Both parents and preschool workers felt that the present ratio was not good enough. Below is a typical example:

Also I feel that for the present education (system) in Hong Kong, the ratio of students to teachers is too high. (Group 9: C25)

To sum up, participants recognized that early childhood education was important but they considered that the government was neither playing an active role nor investing enough resource in early childhood education and there was no government department primarily responsible for early childhood education. They pointed out that the result was that early childhood education became a commercial enterprise which was cost conscious and market-oriented and it was difficult to attract well qualified preschool workers or to provide good teacher/child ratio. Stakeholders reckoned that there were fundamental problems with the whole education system which was putting too much emphasis on academic skills.

20. Suggestions for service provisions

There were several major categories of suggestions for service provision. They included parenting education, service collaboration and co-ordination, and government resources and policies.

20.1 Parenting education

All sectors recognized the importance of parenting education and they emphasized that this should start early. This view can be illustrated by the following quote:

I also feel that in kindergarten, parent educationⁱⁱ is the responsibility of the society. Because they (parents) are very young; many of them are in their twenties or just thirty and they are parents. There are also many professionals, but it does not mean that they have knowledge of child development, or child education, and so I think there is a need to let them know. (Group 2: L25)

Social workers, academics and health professionals further argued that parenting education should start during the antenatal period. Two of them stated this point as follows:

One, the first step of education should start during pregnancy. Second, responsible parenthood. (Group 4: C43)

Before birth, (expectant parents) are very receptive, and have lots of expectation about the baby. (We) hope to prepare (them) as early as possible. At that time, the baby has not been born, and they have the motivation to deal with this. By the time the baby is born, it wets and soils all day and (they) have no time to attend (parenting education) classes. Therefore, I say, (we should) try and give them these (parenting education or information) as much as possible before birth. (Group 15: J41)

In terms of the content of parenting education, the participants' views were quite divided and during the focus group discussions, many topics were mentioned, including physical health and motor skills, moral and civic education, self-esteem, parent-child relationship and home school co-operation. Participants emphasized that knowledge, attitudes and skills components should be included in parenting education and anticipatory guidance was necessary.

On the other hand, parents, preschool workers, social workers and health professionals pointed out that there were many parents who were not participating in parenting education, due to lack of time, or money, or motivation. They further pointed out that those most in need of parenting education were not participating. Below are some typical examples:

Those who are willing to come to our workshops, willing to come to our support groups, actually are clients who do not need much help. The neediest ones are the ones who will not come. This is the worst. The worst is that there is no way to help this group. (Group 13: A112)

Our school had organized parent education talks. Actually, the parents' attendance rates were not that high. They have to work; they have to do this and that. Their (working) time is getting longer and their work is hard. (Group 3: B34)

ⁱⁱ In the quotes, the term 家長教育 is translated as "parent education" and the term 親職教育 is translated as "parenting education".

On the other hand, some parent participants explained that they did not see the need to attend parenting education or they had heard that it was not that useful. Two mother participants explained their views as follows:

(I) haven't so far, that is, have never enrolled (for parenting education), not much need. My child is gradually getting older. For example, first time mothers, I don't know. Their babies are little, and (they) have never looked after babies and (they) might participate (in parenting education), but I have never attended these things. (Group 8: B43)

(I) haven't (participated). My husband has a friend who had listened to these (parenting education) talks but she said that it was not much use. She said it was no use listening (to the talk). (Group 10: A68)

Though the importance of parenting education has been emphasized by all sectors, it is also realized that there are still problems in motivating parents to attend these activities. The stakeholders' views about low parent participation in parenting education is consistent with the survey results on parent participation in chapter 3. Some of the possible solutions are discussed in the sections on service collaboration and co-ordination and government policies.

20.2 Service collaboration and co-ordination

The issue of service collaboration has been mentioned by all sectors. All parties maintained that there were services around in the community but collaboration and co-ordination were needed to avoid competition for resources, and overlap of services as well as to ensure efficient use of resources. The general issue of service co-ordination can be illustrated by the following quote:

Also, I feel that co-ordination is very important. Everyone is doing his/her own thing. Everyone has his/her own programme....But the issue is how to co-ordinate between departments, between bureaux, the passing on of resources among parties, and so the resources will not be wasted...I am not saying that we should all use the same book, but if there is some interface on the basic things, some common points, then there is a direction and an area, and so when we do things, resources will not be wasted. Co-ordination is very important. (Group 4: D55)

Collaboration and co-ordination among service providers could lead to more efficient use of resources and less overlap. Apart from this, collaboration among different sectors has been discussed in some length. In most cases, the issue discussed was the collaboration between kindergartens/crèches/day nurseries and the health and social service sectors. For example, the issue of collaboration between social services and preschools was raised by both preschool workers and social

workers. Their views can be illustrated by the following two quotes. The first was from a preschool worker, and the second, from a social worker:

We do not have social workers...The supervisor knows that they (parents) have lots of stresses, family stress, emotional stress, but a lot of times, because we do not have the professional knowledge, it is hard for us to help them. (Group 1: L56)

We have a dream, that is, one social worker per (pre) school. This is because I can see that a lot of supervisors are doing lots of counselling...In day nurseries, parents will take their children to school every week, and (they) have better relationship with the supervisors and teachers, and so when there are family problems, (they) will bring them back to schools. I have heard of parents contemplating suicide, divorce, fathers with work injuries or some other illnesses. The school supervisor is the first one they call for help, probably because they have already established a relationship. As such, the teachers and the supervisors may not have the skills in this area, (and this is) very hard on (them). That's why I have such a dream. (Group 4: D47)

Apart from collaboration with social services, preschool workers also claimed that closer collaboration with the health sector, including nurses and doctors, was necessary. The thoughts of the preschool workers can be illustrated by the two quotes below:

In mainland China, there are some schools where they have a nurse everyday, who will examine the children when they go into schools ...However, in Hong Kong, this is relatively rare. If you depend on us teachers, we may not have professional knowledge in this area...In terms of physical health, can there be more support for us kindergartens? We kindergartens are in deep waters and if Department of Health, or the government, can give us more support, (this) can reduce our teachers' worries in this area, maybe. (Group 2: C65)

If we can have one doctor per school, then it will be most ideal...We have contacted some doctors (to see) whether they could give us some support. That is, if we have questions, can we contact them directly? Then they can give us professional knowledge, help us solve problems. (Group 3: D52)

Health professionals, including doctors and nurses, were positive about the idea of outreach service in preschools. They explained their views in the following quotes:

I think that the XXX community service is quite good, going into kindergartens to assess the children. Actually, (they) can round up many three-year-olds who are not going to MCH (centres), and the parents' responses are quite good. (Group 12: D72)

I have recently received an email on (the) one school one doctor (scheme). Now (we) stick to answering questions on SARS, but SARS will be over. Actually, this programme is worth continuing...I think one doctor one school is quite good. (Group 14: G67)

The preschool workers felt that they needed more support from the social and health sectors. There were two reasons. First, preschool workers felt that they themselves did not have the expertise in social work or health to deal with these problems in parents or children and they needed the support of these professionals. Second, parents often approached childcare centres/kindergartens about their personal problems and their children's health needs. A smooth referral process or better co-ordination would ensure parents' easy access to service. This idea was also supported by the social service and health professionals as they felt that they could reach the children and parents in need through preschools. This might have some implications for parenting education because the various survey results reported in chapter 3 show that parents most often access parenting education through schools. Collaboration between preschools, the health and the social service sectors could more effectively bring parenting education to parents.

In addition, health sector participants also regarded the co-ordination between MCHCs, private paediatricians and hospitals as important. This would ensure that every party has a complete record of the child's health history and therefore, continuity of care. The private practitioners felt that they did not know about the child's MCHC assessment results and the MCHC doctors had no sure way to find out the kind of treatment given or investigations conducted for the child by private practitioners. This issue can be illustrated by the following quotes, the first from a private practitioner, and the second from a MCHC doctor:

The child attends a screening. After screening, we don't know what has happened. (The patient) does not bring back the report, so what is the report about? (The system) is centre oriented, that is, not patient or the doctor oriented. (Group 15: D101)

I think that sometimes there are interface (issues) with the private (health sector), as we maternal and child health centres do not treat major illnesses...In the case when a child was sick, in the past, if (we were) lucky, we were able to find out. If (we were) unlucky, (we) would miss a lot of things. (Group 16: H86)

Other participants also pointed out the interface problem between MCHCs and the hospitals, which created considerable difficulties for patients. One participant explained this as follows:

Actually, I think there are two extremes in the service. At one end is the MCH (centre), maybe, their doctors are general practitioners, and they will not sort out

the problem well. At the other extreme is the hospital specialist, or special consultation. You know that the door is high and it is difficult to make appointments. Even for booking an appointment, (you) have to be there in person...Therefore I think that the middle level service can be more immediately accessible, and there is no need for that much formality. (Group 15: J29)

According to the health professionals, access to different types of services is difficult for the patient. Furthermore, not getting a complete picture of a child's medical history could create problems for the attending doctor. Closer collaboration between the private and public sector, as well as between MCHCs and hospitals is deemed necessary.

Not only did the stakeholders emphasize collaboration and co-ordination within and across sectors, they also made suggestions about solutions. They suggested that the collaboration and co-ordination should be at the local community level. They explained this idea in the following quotes:

In U.S., they also have that kind of project in the community, in a small community. They have one community centre providing all round service for 0 to 5 years children. Also, they will go to co-operate with preschools, kindergartens or childcare centres. They work closely with the parents, teachers and all expertise together, a one-stop service. (Group 11: B78)

Actually, I think this can be community-based. For example, in your community, some day nurseries, kindergartens, that is, everyone and us, maternal and child health centre, we have some connections. (Group 13: F73)

Every school is doing it. Department of Health is doing it. Voluntary organizations are doing it. But, (we) do not know whether the things (we) get are consistent or not. If there is a base, a community base, whether it is the voluntary organization, or the crèche as a base, we can co-operate with one another. I think this will be a better use of resources. (Group 3: A71)

Furthermore, to facilitate the keeping of a complete record of a child's health history, some health professionals and parents suggested the idea of a "family doctor" who would keep the complete record. This view is explained by one participant as follows:

Actually there is the need for something like family doctors...He/she will actually follow the child, at least till primary school, or before secondary school. He/she will have a clear picture of the child's development...At least he/she is a doctor, who can, from a record, know how the child is developing all along. (Group 6: E42)

In short, the preschool sector, the health sector and the social service sector were all indicating the need for collaboration and co-ordination and they were all in favour

of closer collaboration. The idea of a local (geographically based) community-based collaboration model was supported.

20.3 Government policies

It was reckoned by the stakeholders that without government support and resources, promoting the well-being of preschool children would be impossible. One participant summarized this view as follows:

I think the most important point is that the government must have two things, resolve and resources. If the government does not have these two things, there's no use talking about it. (Group 14: A56)

In particular, participants strongly emphasized the need for government policies to support family life, to support parenting education, and to monitor the quality of kindergartens. These views can be illustrated by the following quotes:

Personally, I would like to have the government actively intervene...I think it is a very active intervention to tell them that at home, kids need rest and play and spend time with parents and probably it's the right time for the government to be actively involved and help to do something like that. (Group 11: E55)

It should start with the government thinking of things to do, right? Can there be legislations? Can organizations, for example, grant some leaves to employees with children? They can take these leaves to attend some parent education. (Group 3: F54)

Also, the kindergartens, I don't know what the Education and Manpower Bureau can do. Actually, I know that the Education and Manpower Bureau has some very standard criteria for them...However, to make money, to make (themselves) famous, the kindergartens raise the level themselves. If this can be under better control, I think it will benefit children 0 to 5. (Group 16: B68)

Social workers and academics suggested that there should be registration or licensing for child minders and training should be provided to these people. One participant explained this point as follows:

Private child minders can be a market, and it is a guarantee for child rearing. If (we) can do better in terms of training and registration, that is, having a mechanism to ensure the quality of the carer. (Group 5: F58)

At the highest level, government policies on child health and parenting education were suggested. Participants considered it important for the government to take the lead in providing services for preschool children and their families.

Summary

There are programmes catering for the physical, cognitive and social emotional development of children provided by various sectors. There are also programmes for children with developmental delays though the figures reveal a fair number of children on the waiting list for services. Furthermore, there are programmes for families and parents.

Nonetheless, the stakeholders are concerned about the present state of early childhood provision. There are three government bureau/departments, namely health, education and social welfare, focusing on different age groups and different aspects of children's needs. Stakeholders are concerned that the education of children aged 3 to 6 is left in the hands of the non-governmental and private sectors. Referral within or across sectors is regarded as complicated and children and their parents are often caught in between. Stakeholders from all sectors are calling for more government leadership in preschool education, government support for parenting education as well as better co-ordination and collaboration across and within sectors. There is also the view that moral and civic education should be given more emphasis.

At the local community level, closer collaboration among preschools, the health sectors, and the social service sectors are suggested. Stakeholders reckon that more proactive outreach strategies into preschools by the health and social service sectors are needed so that services can reach more parents and children, and more support can be provided to preschools.

At a higher policy level, closer collaboration and co-ordination among the three departments/bureaux and joined-up government policies are vital to promoting the well-being of preschool children.

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Chapter 5

Effectiveness of Current Programmes

In this review on the effectiveness of current programmes, both local and overseas programmes are included. For local programmes and services, the purpose is to give the reader information about effective local programmes and local programme evaluation activities. Information on individual evaluation studies of programmes and services are given, where possible. However, it is not possible to report every evaluation study as it depends on the availability of information supplied by programme and service providers. Information on quality assurance and commissioned service review of local programmes and services is included, because these measures and reviews are considered as means to monitor and improve the service. The data sources include information supplied by government departments, information supplied by NGOs in response to the invitation letter from the Hong Kong Council of Social Serviceⁱ, published reports and papers.

As the focus is on local programmes and services, in the case of overseas programmes, the emphasis is on published systematic review reports. The choice of overseas programmes to be reported is also guided by the areas of health concerns identified in chapter 3.

Before reviewing the effectiveness of the programmes, it is necessary to first define the terms to be used in this chapter.

Terminology

1. Types of programmes

- Universal preventive interventions/programmes – targeted at all children or parents in a geographic area without selective criteria (Webster-Stratton & Taylor, 2001).
- Selective preventive interventions/programmes – targeted at children or parents at risk because of various factors (Webster-Stratton & Taylor, 2001).
- Indicated preventive interventions/programmes – targeted at children or parents with confirmed diagnosis (Webster-Stratton & Taylor, 2001).

ⁱ To avoid repetition of information regarding source of data, all information supplied by NGOs in response to the invitation letter from the Hong Kong Council of Social Service is listed under the social service sector, though it is recognized that some might be health or education services.

2. Research design

- Randomized controlled trials (RCTs) – “an experiment in which participants in a population are randomly allocated into groups, usually called study and control groups, to receive or not to receive an experimental preventive or therapeutic procedure, manoeuvre, or intervention. The results are assessed by rigorous comparison of appropriate outcome in the study and control groups. Randomized controlled trials are generally regarded as the most scientifically rigorous method of hypothesis testing available in epidemiology” (Last, 2001, p. 150).
- Cohort study (CS) – “the analytic method in which subsets of a defined population can be identified who are, have been, or in the future may be exposed or not exposed, or exposed in different degrees, to a factor or factors hypothesized to influence the probability of occurrence of a given disease or other outcome. The main feature of cohort study is observation of large numbers over a long period with comparison of incidence rates in groups that differ in exposure levels” (Last, 2001, p. 33-34).
- Case-control study (CC) – the study of persons with the outcome variable of interest and an appropriate control group of persons without the outcome variable. “The past history of exposure to a suspected risk factor is compared between the cases and controls” (Last, 2001, p. 22).
- Quasi-experiment (QE) – “a situation in which the investigator lacks full control over the allocation and/or timing of intervention but nonetheless conducts the study as if it were an experiment, allocating participants to groups” (Last, 2001, p. 149).

3. Measurement of outcomes in health promotion

According to Nutbeam (1998), distinguishing between various types of outcomes associated with health promotion activities is important. Nutbeam (1998) puts forward a hierarchy with three levels of outcomes.

- Health and social outcomes – examples of social outcomes are quality of life, functional independence, equity, and examples of health outcomes are reduced morbidity, disability, avoidable mortality. This type of outcome is at the top of the hierarchy and is regarded as the end point of health and medical intervention (Nutbeam, 1998).
- Intermediate health outcomes – these are modifiable determinants of health such as healthy lifestyles (e.g. food choice, physical activity), effective health services (e.g. provision of preventive service) and healthy environments (e.g. safe physical environment). These outcomes represent the determinants of health

and social outcomes (Nutbeam, 1998).

- Health promotion outcomes – these are intervention impact measures including health literacy (e.g. health-related knowledge, attitudes, motivation), social action and influence (e.g. community participation) and healthy public policy and organizational practice (e.g. policy statements). These represent the more immediate results of health promotion activities (Nutbeam, 1998).

4. Evaluation and related terms

- Evaluation – “a process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, and impact of activities in the light of their objectives” (Last, 2001, p. 64).
- Impact/outcome evaluation – “assessing outcomes in order to determine the extent to which the intervention has achieved what it was established to achieve” (Nutbeam, 1998, p. 33). In health promotion, impact evaluation typically involves measuring changes in health promotion outcomes. Outcome evaluation involves measuring changes in intermediate health outcomes (intermediate outcome assessment), as well as social and health outcomes (health outcome assessment) (Nutbeam & Harris, 1999; Nutbeam, 2001) (see section 3).
- Process evaluation – “understanding the process in order to identify the basic conditions for successful implementation of an intervention” (Nutbeam, 1998, p. 33).
- Formative evaluation – “evaluating or assessing a product while that product is in the process of being created and shaped” (Beyer, 1995, p. 7).
- Efficacy – “the extent to which a specific intervention produces a beneficial result under ideal conditions. Ideally, the determination of efficacy is based on the results of a randomized controlled trial” (Last, 2001, p. 58).
- Effectiveness – “a measure of the extent to which a specific intervention, when deployed in the field in routine circumstances, does what it is intended to do for a specified population” (Last, 2001, p. 57).
- Quality assurance – “system of procedures, checks, audits and corrective actions to ensure that all research, testing, monitoring, sampling, analysis, and other technical and reporting activities are of the highest achievable quality. The term is used in health services with the same meaning” (Last, 2001, p. 147).
- Clinical audit – the process of reviewing the delivery of services to identify deficiencies so that they can be remedied (Baker, 1999).

Types of evidence

In evaluating the quality of different types of evidence, Elwood (1998) suggests that it is useful to consider a hierarchy of evidence. At the top are RCTs and evidence from these studies should be given the greatest weight as they are best able to overcome problems of bias and confounds. The second are CS and CC designs and the third are studies comparing groups of participants not selected specifically for the aim of the study but representing different population groups. The fourth category consists of anecdotal evidence based on clinical judgement or personal experience. However, it is recognized that it is not always practically or ethically possible to conduct RCTs, especially in the case of universal preventive programmes, and evidence from well-designed evaluation research using quasi-experimental design is also an important source of information (Nutbeam, 1998). In health promotion, as described in section 3, there are multiple outcomes, and multiple strategies are used to achieve these outcomes. Multiple strategies are used to evaluate the achievement of these outcomes.

Local programmes

5. Programmes in the health sector

5.1 Family Health Service (Integrated Child Health and Development Programme)

- Parenting programme - formative, process and outcome evaluation of the programmes are conducted, where appropriate. New programmes and materials are piloted and formative evaluation is conducted to ensure that they are relevant and appropriate to clients and staff. Data on staff training, resources material produced, service utilization, as well as questionnaires with nurses are also collected and analyzed. Annual survey of breastfeeding rate is routinely conducted as outcome evaluation. For parenting programmes, the effectiveness of the Triple P (3P 親子正策課程) was evaluated before implementation of the programme using RCT involving 69 parents who were randomly assigned to the intervention (TP) and a waitlist control group (WL). There was no significant difference in pre-intervention measures between the two groups. However, at post-intervention parents in the TP group reported significantly lower levels of child behaviour problems, lower dysfunctional discipline styles, higher parenting sense of competence, and improved family relationships, compared to the WL group (Leung, Sanders, Leung, Mak, & Lau, 2003). The participants in this study included clients from the CAS and MCHCs. A database on the pre-intervention and post-intervention measures on parenting stress and child behaviour is maintained for MCHC and CAS clients participating in the Triple P.

- Health and developmental surveillance programme
 - Newborn examination, growth monitoring and developmental surveillance programme – formative evaluation of the information leaflets (checking for clarity and parents’ understanding of the messages), and the developmental surveillance questionnaire (checking for clarity, practicability, appropriateness, ease of understanding by parents and nurses) has been conducted. There is also a documentation of the programme coverage and staff workload.
 - Hearing screening programme – a one-year pilot project using the AOAE test in 4 MCHCs showed that the AOAE test was a more valid test (with higher sensitivity and specificity) than the Distraction Test formerly used (Chan & Leung, 2004). Since implementation of the AOAE in August 2003, there is continuous evaluation of the programme through maintenance of a database on coverage, age of testing, repeat and referral rate, reply from specialist, and hearing risk indicator.
 - Vision screening programme – to evaluate the effectiveness of the vision screening programme, a database on coverage, age of testing, types of tests used, repeat and referral rate, and confirmed diagnosis from specialists is being kept and monitored.
- Immunization programme – the immunization coverage is routinely monitored. There is also a system of immunization safety surveillance in the form of monthly statistical return on adverse reactions after immunization. The major goal of the surveillance is early detection and appropriate and quick response to adverse events in order to lessen the negative impact on the health of individuals and on the immunization programme. This is also to ensure that coincidental events are not falsely blamed on immunization.

5.2 Child Assessment Service

Most of the evaluation studies are related to the treatment programmes. The outcome evaluation of the Triple P (group programme) has been reported in section 5.1. The evaluation of the Triple P (individual programme) using randomized controlled trial has just been completed. Evaluation of other treatment programmes is in the form of client satisfaction questionnaires. A database on the pre-intervention and post-intervention measures on parenting stress and child behaviour is being kept for clients participating in the Triple P.

6. Programmes in the education sector

6.1 Pre-primary education

In order to help establish the culture of self-evaluation in kindergartens and to provide reference for the public in assessing the quality and standard of pre-primary education, the EMB has developed a set of performance indicators for pre-primary institutions in Hong Kong. Commencing in the 2000/01 school year, quality assurance inspection was launched to further promote the development of quality early childhood education. Quality assurance is based on a set of common, open and objective performance indicators. It is built on interactive and transparent quality assurance processes, namely school self-evaluation and quality assurance inspection. For school evaluation, each school works out its development plan based on the school aims and implements the plan. The school conducts self-evaluation and produces an annual report towards the end of the year for parents' information. Quality assurance inspection by EMB provides an external review on the performance of the school as a whole and to make open inspection findings (Education and Manpower Bureau, 2003a).

6.2 Parent Education Initiative

The resource materials produced by the Parent Education Implementation Team are subject to formative, process and outcome evaluation. For the parent education pamphlets, formative evaluation is conducted where draft pamphlets are sent to 30 parents and one external expert for comments. For the parent education manuals, the primary school series, Universal Parent Education Programme for Parents of Primary School Children (親職學習多面體 – 小學篇) was evaluated using non-equivalent control group design, involving 52 parents in the intervention group and 32 parents in the control group. At post-intervention, intervention group parents reported significantly lower child behaviour problems and parenting stress than the control group parents (梁敏 & 曾潔雯, 2003). Process evaluation was conducted through focus group discussion with participants and facilitators. The programme consisted of six two-hour sessions on topics like the role of parents, self-esteem, communication, behaviour management and learning. No evaluation results were reported for the preschool children and adolescent series.

6.3 Parent-teacher associations (Education and Manpower Bureau, 2003b)

This evaluation of the effectiveness of parent-teacher association study was commissioned by the Committee on Home-School Co-operation, and both quantitative and qualitative methods were used. The effectiveness of parent-teacher associations was investigated through a comparison of schools with and without

parent-teacher associations. It was found that parents in schools with parent-teacher associations participated more in home-school co-operation activities, reported better relationship with schools, and better communication with their children.

6.4 Balanced education project (Pang, Wong, & Leung, 2002).

This project aimed to promote balanced education. Learning and evaluation activities in the emotional and spiritual domains were provided. A total of 28 primary and secondary schools participated in the project, with 31 teacher questionnaires and 563 student questionnaires returned. Most of the students and teachers endorsed the balanced education framework and reported that the evaluation activities helped them understand students (teachers) and themselves (students). There was no pre- and post-programme measurement reported and there were no comparison schools.

7. Programmes in the social service sector

As mentioned in chapter 2, a letter has been sent to various NGOs, via the Hong Kong Council of Social Service, requesting them to supply information on their programmes for preschool children and their families, as well as programme evaluation details. The information below is based on available published research reports and papers on service reviews, programme evaluation studies with pre- and post-measures, and the returns of the NGOs. It is possible that there might be other in-house programme evaluation activities which have not been published or reported.

7.1 Review of family services

The Department of Social Work and Social Administration, The University of Hong Kong, was commissioned by the SWD to review the family service programmes in Hong Kong in 2000. There were five main approaches in the review process: documentary review, focus group discussions with stakeholders, compilation of service statistics, individual case studies and consultation with fieldworkers, users and policy makers (through electronic and written correspondence and sharing sessions). The review indicated that the family service programmes were meeting people's needs in many ways but the service was fragmented. Some services were overloaded while others were underutilized. There was also a concern about the ability of the service to reach the hard-to-reach families. The review recommended a re-structuring of the existing FSCs into IFSCs. The IFSC model, which comprises a family resource unit, a family support unit and a family counselling unit, will provide a continuum of preventive, support and remedial services to strengthen families. The service should be provided under an integrated family service centre comprising

family life education, support and developmental groups, volunteer development, referral for tangible service and counselling service etc. The review also pointed out the need for the development of objective indicators of community needs and assessment tools in the context of the Hong Kong situation (University of Hong Kong, 2001). Fifteen two-year pilot projects of IFSCs were implemented from April 2002 to March 2004. In the interim report on the Evaluative Study of the Pilot Projects on IFSCs submitted by the University of Hong Kong in May 2003, IFSC was found to be a more desirable mode of service delivery than the traditional FSC. With such findings and support from various advisory bodies, SWD will transform all existing FSCs to become IFSCs by phases in 2004-05.

7.2 The healthy start home visiting programme (生之喜悅家庭探訪計劃) (Against Child Abuse)

This was a three-year pilot project from 1997/1998 to 1999/2000. The target clients were new parents and parents-to-be living in Tuen Mun, Yuen Long and Tin Shui Wai. Socially isolated families, or families with emotional, social or financial difficulties were given priority. Families were expected to commit themselves to the programme for one year. Volunteers visited these families regularly to provide information and support on childcare and the participants participated in sharing programmes. The volunteers were supervised by social workers. Mothers in the service group were referred by professionals whereas mothers in the control group participated voluntarily. Mothers in both groups completed pre- and post-questionnaires. The results indicated that home visiting service in the present form significantly reduced loneliness and depression among mothers in the service group, but there was no difference between the two groups in parental attitude and marital satisfaction (Against Child Abuse, 2000).

7.3 Rainbow project (彩虹計劃) (Against Child Abuse)

This was a pilot project conducted between 1999 and 2001. This project consisted of child sexual abuse hotline, drop-in service, investigation and casework service, two therapeutic groups for non-offending parents and survivors, talks and sharing forums, production of a CD ROM on child sexual abuse and a project report. Pre- and post-intervention questionnaires were used in the evaluation of the two therapeutic groups which were based on a Cognitive Behavioural Therapy Model. The questionnaires consisted of a Post Trauma Stress Response questionnaire and a Problem Identification Questionnaire. Out of the 11 participants, it was reported that 8 of them showed improvement in Post Trauma Stress Response. All participants

indicated improvement in relation to the problems identified in the Problem Identification Questionnaire (Against Child Abuse, 2002).

7.4 Growing with self-esteem – a parent education project (自尊自信成長樂 – 幼兒家長教育計劃) (Tung Wah Group of Hospitals)

The programme consisted of 20 units of self-learning coursework materials, 5 face-to-face tutorials and 2 public seminars for parents and the duration of the programme was 7 months. The participants included 1 175 parents from 11 schools. The results indicated significant difference in parents' self-evaluation of their frequency in engaging in behaviours in enhancing children's self-esteem between the high participation parents and the low participation parents. Parents who completed most of the coursework; parents who completed most of the tutorials and parents with monthly family income over \$20,000 benefited more from the programme. Originally, data from 54 control group parents was collected but the data was not used in the analysis because of the large discrepancy in number between the intervention and control groups (Centre for Child Development, Hong Kong Baptist University, 2002).

7.5 Evaluation initiated by the Hong Kong Council of Social Service (Cheung, 2001)

This study examined the effectiveness of 18 parent education programmes of four to six sessions in duration. These programmes were conducted by different NGOs. There were 130 mothers in the sample which was not restricted to parents of preschool children. The results indicated significant changes in parental empathy, parental efficacy, social support and parental satisfaction after programme participation. However, mothers aged 40 and above and those with more than one child did not experience positive gains in parenting satisfaction after the programme. Results also indicated that social support was the most important determinant of parenting satisfaction. The study did not examine changes in child behaviour.

7.6 Other evaluation studies

Three other studies on individual parenting education programmes were reported in the literature. Cheung and Yau (1996) evaluated the effectiveness of the Parent Effectiveness Training (PET) programme. There were six PET groups conducted by various family life education units serving mainly working-class population. The participants included 31 mothers with children in the school-going age. Pre- and post-intervention measures were used and there was no control group. The participants showed improvement in their ability to empathize with their children and

to listen to them actively.

In another study to examine the effectiveness of the Systematic Training for Effective Parenting programme, a quasi-experimental design involving pre-test-post-test non-equivalent control design was used. The participants consisted of 8 fathers and 8 mothers attending a children and youth centre (Kwok, 1994). The control group participants with similar background were selected from the same centre. There was no information on the age of the target children. The results indicated that the programme was effective in changing mothers' parenting skills, attitude and knowledge and child behaviour. However, for fathers, there was only change in childrearing knowledge.

Ho et al. (1999) studied the effectiveness of a parent management training programme on 25 parents of children referred for management of aggressive and defiant behaviour. The children were between the ages of 4 to 10 years old. There was a significant decrease in child behaviour problems after treatment. There was no control group.

7.7 Parent education database

Three NGOs have joined hands with the EMB, DH and University of Hong Kong to establish a database on the evaluation of parent education programmes. Ten parent education programmes for parents of preschool, primary school and secondary school students were included in the pilot phase. All participants were requested to complete a set of questionnaires before and after completion of the programmes. The data could potentially provide information on the effectiveness of different types of programmes, and the effectiveness of the programme for clients from different backgrounds etc. The initial results indicated that overall, the programmes could lead to decrease in child behaviour problems and parenting stress (Leung & Tsang, 2003).

7.8 Family violence and child abuse

To have a better understanding of family violence in Hong Kong and to facilitate formulation of prevention and intervention, SWD has commissioned the University of Hong Kong to conduct a two-year study on Child Abuse and Battered Spouse in April 2003.

7.9 Returns from NGOs

The table below summarises the returns from various NGOs, in response to the invitation letter from the Hong Kong Council of Social Service, regarding their programme evaluation activitiesⁱⁱ.

Table 10
NGO programme evaluation activities

Organization	Programme	Programme evaluation
Hong Fook Church Bradbury — Community Health Development Centre	親子遊樂場	Client satisfaction questionnaire: children were more active and the programme provided chances for parents to share experience
Hong Kong Christian Service	Parent Education Project	Client satisfaction questionnaire: >80% felt satisfied or very satisfied
Playright Children's Play Association	Outreach play programme - hospital pre-admission tour	1. Two appreciation letters from participants 2. Excess requests from nurseries / kindergartens
	Play resource centre	Programme evaluation form: more play programmes on weekdays and for children under 2
St. James' Settlement	Happy Family with Happy Children	---
The Boys' & Girls' Clubs Association of Hong Kong	Happy Child Development Project	---
The HK Family Planning Association	Early Childhood Sexuality Education In-School Programmes: Parent Talks & Teacher Training Programmes	Client satisfaction questionnaire: 80% satisfied
The Hong Kong Society for the Deaf	Parents Resource Centre	---

ⁱⁱ The returns include some of the programmes described in sections 7.2 to 7.4. They are not repeated in Table 10.

Organization	Programme	Programme evaluation
The Salvation Army	Child Care Resource Centre	---
United Christian Nethersole Community Health Service	Preschool Health Maintenance Program	---
Yang Memorial Methodist Social Service	家長管教活動/家長教育	Course evaluation form – result were not provided
	親子活動及兒童成長活動	Programme evaluation form – results were not provided
	已婚婦女情緒支援熱線	Verbal comment from clients: helpful
	孕婦, 媽媽及幼兒健康熱線	---
The Spastics Association of Hong Kong	啓幼計劃—言語治療服務	---
Caritas	Comprehensive intervention programme for autistic children	<ol style="list-style-type: none"> 1. Parents opinion survey was conducted annually, as well as half yearly review of cases with parents' participation 2. Application of the Psycho-Educational Profile Revised before and after the training programmes to assess the progress of the cases in their developmental areas
Ebenezer School	Early Intervention Programme for the Visually Impaired Children	---

8. Views from stakeholders

The issue of programme evaluation has not been raised by many of the stakeholders. Nevertheless, some participants including preschool workers, parents, social workers and paediatricians mentioned this issue, together with other related

issues, such as the need for updated local norms and assessment tools, surveys of the current status, and health indicators, all of which are related to programme evaluation. Below is one example:

Do we have any pilot study? If there is rehabilitation, getting some volunteers to work, then how do we evaluate these programmes?...Or when you are doing the Triple P evaluation, what is it like? (Group 14: H28)

9. Summary

While there are service reviews and mechanisms for monitoring the quality of services in the three sectors by the three government bureau and departments, programme evaluation activities using RCTs or QE designs are still relatively limited. Most of the programme evaluation activities are in the form of client satisfaction questionnaires or programme evaluation forms. For those using control groups and pre- and post- measures, most of the programmes evaluated are parenting education programmes, and the available information indicates that these programmes could produce desirable changes in clients. Only a few of the stakeholders mentioned the need for rigorous research to evaluate programme effectiveness.

Overseas programmes

In the review below, broad categories of programmes for preschool children and their families are reviewed. The purpose is to give readers an overview of evaluation studies of major categories of available services and programmes for preschool children and their families. In some cases, there are overlaps and some programmes may fall into more than one category. For each category, characteristics of programmes and evaluation results are discussed but it should not be regarded as a comprehensive list of available programmes. The choice of the categories of programmes to be covered is, as mentioned before, to some extent, guided by the service needs identified in chapter 3.

10. Physical domain

In chapter 3, obesity, nutrition, lack of physical activity, child abuse, injury prevention, breastfeeding and oral health have been identified as areas of concern within the physical domain. Reviews of the effectiveness of overseas programmes on these issues are discussed below. It should be noted that many of these health promotion programmes employed multiple intervention strategies, with multiple outcomes including health outcomes such as reduced morbidity, intermediate health outcomes such as healthy lifestyles, and health promotion outcomes such as health literacy described in section 3. There are many different ways of determining the

success or failure of these programmes. Many of these programmes are universal programmes.

In the discussion below, the programmes would be categorised according to the types of programmes described in section 1. They include universal (U), selective (S) and indicated (I) programmes. For the outcomes, they would be classified according to the classification in section 3. They include health and social outcomes (HS), intermediate health outcomes (IH) and health promotion outcomes (HP). For research design, they would be categorised according to the research designs described in section 2, namely, randomized controlled trial (RCT), cohort study (CS), case-control study (CC) and quasi-experiment (QE).

10.1 Programmes for preventing obesity in children

In a review on school-based and community-based programmes to prevent obesity in children (dietary education and physical activity), the results are mixed, and no firm conclusions could be drawn about the effectiveness of obesity prevention programmes (Campbell, Waters, O’Meara, & Summerbell, 2001). Few studies are on preschool children.

Table 11

Examples of programmes to prevent obesity among preschool children (Campbell et al., 2001)

Programme	Mode and content	Outcome
School-based dietary education programme (U) ⁱⁱⁱ	Two types of intervention – multimedia action (MA) involving printed pamphlets, audiovisual aids and qualified staff versus written action (WA) involving only distribution of printed pamphlet. Participants were children aged 3 to 9 years old	Using QE design ($n = 1\ 321$), the results indicated that at 12 month follow-up, there was a 12.2% reduction in obesity and a 12.1% reduction in overweight in MA group but not in WA or control group (HS)
Exercise programme (U) ⁱⁱⁱ	An exercise programme (walking and aerobic exercise) over 29.6 weeks for Thai kindergarten children	Using RCT design, results indicated almost significant reduction in prevalence of obesity in the intervention group ($n = 158$) versus control group ($n = 152$) (HS)

ⁱⁱⁱ Cited in systematic review

10.2 Nutrition education programmes

A review of nutrition education programmes indicates that most programmes are effective in changing knowledge but the evidence is not clear with regard to nutrition behaviour and health status. It is noted that for programmes to be effective, parental involvement is essential. It is also important that the programmes are developmentally appropriate and are activity-based and food-based. Staff training is essential for the success of the programmes (Swadener, 1994). However, different measures were used in the programme evaluation and this should be taken into consideration in the interpretation of the results.

Table 12

Examples of nutrition programmes for preschool children (Swadener, 1994)

Programme	Mode and content	Outcome
Programmes to change nutrition knowledge		
Home-based nutrition programme (U) ⁱⁱⁱ	4-week home-based nutrition education programme on the role of food and nutrition in health for children aged 4 to 7 years old, using audio cassettes and picture books	Using RCT design ($n = 60$), results indicated significant increase in the experimental group children in the perception that health and nutrition were related concepts (HP)
Nutrition knowledge (Essa, Read, & Haney-Clark, 1988) (U) ⁱⁱⁱ	10-week preschool curriculum taught at school for preschool children	Using RCT design, children in the parent augmentation programme ($n = 22$) scored higher on nutrition knowledge than those exposed to the school programme only ($n = 23$). Both groups scored higher than the control ($n = 15$) (HP)
Conceptual understanding of nutrition (U) ⁱⁱⁱ	8-week nutrition programme involving use of food profile cards for children aged 3.5 to 5 years	Using QE design, results indicated that children taught at classrooms ($n = 20$) learned significantly better than those taught at homes ($n = 20$) (control group $n = 20$) (HP)

Programme	Mode and content	Outcome
Conceptual understanding of nutrition (U) ⁱⁱⁱ	34 children aged 5 to 11 years old	8 out of 10 of the preschool age preoperational children did not see food as becoming part of the body (HP)
Nutrition education curriculum in preschools (U) ⁱⁱⁱ	12 nutrition activities over 6 weeks	Using RCT design ($n = 187$), the results indicated that children in the treatment group scored higher on post-test nutrition knowledge (HP)
Programmes to change food behaviour		
Behavioural interventions (U) ⁱⁱⁱ	Exposure of preschool children to peer models selecting and eating the target children's non-preferred food	Exposure to peer model was sufficient to cause the child ($n = 39$) to choose the non-preferred food (IH)
Changing food preference by using reinforcement (U) ⁱⁱⁱ	Use of stickers and praise to modify preschool children's food choice during a preschool snack period	Using multiple baseline across subjects design with 17 children, results indicated that reinforcement increased healthy food choice in school, but not at home. Snack choice returned to baseline level after withdrawal of reinforcement (IH)
Student Parent Educator Children (SPEAC) Preschool Nutrition Education Project (U) ⁱⁱⁱ	Integrating the USDA Child Care Food Programme and the education curricula and activities of selected childcare programmes	Using QE design ($n = 168$), the programme increased the acceptance of fruits, vegetables and dairy products (IH)

Programme	Mode and content	Outcome
Public service announcement and television advertisement (Galst, 1980) ⁱⁱⁱ (U)	Exposure of children aged 3.5 years to 6.75 years to public service announcement and television advertisement during a four week period	Using RCT design ($n = 65$), results indicated that television advertisement and pro-nutritional public service announcement with positive evaluative comments by an adult observer was most effective in reducing selection of snacks with added sugar content (IH)
Iowa Nutriphonics (NET Programme) (U) ⁱⁱⁱ	14-unit learning package presented three times per week, emphasizing choosing nutritious foods	Using QE (?) design ($n = 850$), results indicated little difference in food choice made by children participating in the programme and those in the control group (IH)
Food Dude Programme (Tapper, Horne, & Fergus, 2003) ^{iv} (U)	16 day programme including video episodes, additional fruit and vegetable provision, rewards, homepack to encourage fruit and vegetable intake at home, staff manual and briefing video and education support materials	Using a mixture of pre- and post-measure (3 schools) and QE design (1 experimental, 1 control), results indicated increased fruit and vegetable intake in children (IH)
Programmes to change nutrition knowledge, attitudes and food behaviour		
Benefit appeal versus threat appeal (U) ⁱⁱⁱ	Three nutrition education presentations about benefits of vegetables	Using RCT design ($n = 103$), the results indicated that both appeals were effective but the benefit group had higher scores on nutrition knowledge and vegetable snacks (IH) (HP)

^{iv} Original study

Programme	Mode and content	Outcome
Nutrition education curriculum in preschools (U) ⁱⁱⁱ	6-week group-time action stories, songs and self-selected activities involving food	Significant increase in nutrition knowledge but no difference in food behaviour between pre-test and post-test ($n = 16$), but no control group (IH) (HP)
Nutrition education curriculum in preschools (U) ⁱⁱⁱ	Helpful hints preschool health education curriculum	Using QE design ($n = 267$), results indicated moderate impact on child health knowledge but no significant change in feelings and emotions (HP)
Self-contained nutrition education curriculum (S) ⁱⁱⁱ	6-week experiential programme for Headstart children	Using RCT design ($n = 1\ 000$), the results indicated no significant difference in nutrition knowledge and attitude. Experimental group children decreased refusal of food served and increased request for low-sugar snack. Control group children increased refusal of food served and decreased request for low-sugar snack (IH) (HP)

10.3 Programmes to promote breastfeeding

In a systematic review of interventions to promote breastfeeding, Fairbank et al. (2000) point out that health promotion interventions are generally effective in increasing initiation rates. Peer support and professional support programmes are effective in increasing initiation and duration rates. Institutional changes such as rooming-in, early contact and health education have also been found to be effective in increasing initiation and duration rates. There is some limited evidence to show that mass media campaigns could improve attitudes towards breastfeeding which might lead to increased initiation and duration rates. However, the findings suggest that giving out breastfeeding literature on its own, without other formal or informal methods of health education delivery, is not effective (Curro, Lanni, Scipione, Grimaldi, & Mastroiacovo, 1997). In general, De Oliveira, Camacho, and Tedstone (2001) point out that the most effective interventions include a combination of

information, guidance and support and that the intervention should be long-term and intensive.

Table 13

Examples of programmes to promote breastfeeding and programme reviews

Programme	Mode and content	Outcome
Increasing breastfeeding initiation and duration (Martens, 2002) ^{iv} (U)	Community health nurse and peer counsellor programme	Using chart audits ($n = 283$), initiation rates increased from 38% in 1995 to 60% in 1997. Peer counsellor group were less likely to wean (IH)
Increasing duration using information booklet (Curro et al., 1997) ^{iv} (U)	Information booklet	Using RCT design ($n = 200$), the results indicated no significant difference between intervention and control groups in the prevalence of exclusive or complementary breastfeeding at 6 months (IH)
Comprehensive prenatal breastfeeding promotion programme (Pugin, Valdes, Labbok, Perez, & Aravena, 1996) ^{iv} (U)	Prenatal breastfeeding skills group education	Using QE design ($n = 59$), results indicated significant increase in full breastfeeding at 6 months from 32% to 67% (IH)
Breastfeeding promotion through peer counselling (Grummer-Strawn, Rice, Dugas, Clark, & Benton-Davis, 1997) ^{iv} (S)?	Peer counselling programme	Using QE design (?), results indicated that incidence of breastfeeding rose from 12.3% to 19.9% in clinics with the programme, but only from 9.2% to 10.7% in clinics without the programme. Presence of lactation specialists was more important than that of peer counsellors (IH)

Programme	Mode and content	Outcome
Breastfeeding support (Sikorski, Renfrew, Pindoria, & Wade, 2003)	Systematic review of support for breastfeeding mothers	All forms of extra support (professional or lay) have beneficial effects on duration, with clear evidence for the effectiveness of professional support on the duration of breastfeeding (20 RCT or quasi RCT studies with 23 712 mother-infant pairs) (IH)

10.4 Programmes to promote oral health

As the benefits of fluoride in preventing dental caries has been firmly supported (Marinho, Higgins, Logan, & Sheiham, 2001; Marinho, Higgins, Logan, & Sheiham, 2003), the focus of the present discussion is on community oral health education programmes. While there is evidence to show that community oral education programmes are effective in reducing dental caries, Sprod, Anderson, and Treasure (1996) point out that programmes using more innovative approaches are more likely to have long-term effect. Limited short-term behavioural changes are achieved by simple persuasive approaches. Most of the programmes for young children involve their parents as well.

Table 14

Examples of programmes to promote oral health

Programme	Mode and content	Outcome
Community health education programme (Sgan-Cohen, Mansbach, Haver, & Gofin, 2001) ^{iv} (U)	Community health education programme providing structured health education and/or toothpaste/toothbrushes for mothers of infants	QE design ($n = 727$) No intervention: secular 32.5% increase in tooth brushing Toothpaste and toothbrush only: 45.1% increase in tooth brushing Health education only: 43.7% increase in tooth brushing Health education, toothpaste and toothbrush: 60.4% increase in tooth brushing (IH)

Programme	Mode and content	Outcome
Home visit programme in areas of urban deprivation (Rayner, 1992) ^{iv} (S)	Comparison of three groups: tooth brushing in school, tooth brushing in school plus home visit by dental hygienist, parental dental health education by home visit	Using QE (?) design, the results indicated that oral hygiene and gingivitis of first group improved during the study but deteriorated during school holidays. Oral hygiene and gingivitis of the other two groups were maintained during school holidays (HS)
Home visit programme in low socio-economic/high caries suburbs (Kowash, Pinfield, Smith, & Curzon, 2000) ^{iv} (S)	Regular home visits by trained dental health educators over a period of 3 years. Subjects were assigned into different groups receiving dental health education on diet and oral hygiene of various degrees	Significant differences in caries levels and caries risk between the study and control groups (4% vs. 33%). The study group was randomly selected by the computer and the control group consisted of families not selected by the computer ($n = 228$) (HS)

10.5 Programmes to prevent childhood injuries

Three reviews will be reported in this section, together with other studies involving families with preschool children. Many of these programmes for preschool children are home visit programmes and many of them are targeted towards at risk families (e.g. past history of child injury, socio-economic disadvantage). The three reviews are on child injury prevention counselling in primary care settings, home visit programmes and community actions involving multi agencies (Bass et al., 1993; Roberts, Kramer, & Suissa, 1996; Towner & Dowswell, 2002). Most of the interventions are able to demonstrate some favourable changes. However, there is no clear pattern about the relative effectiveness of particular types of approach as many of the intervention programmes employ a combination of approaches. Furthermore, the target outcomes and the success indicators vary tremendously from programme to programme, including changes in injury rates (health outcome), or changes in behaviour (e.g., installation of booster seat) (intermediate health outcome) or changes in parent knowledge of child injury related issues (health promotion outcome). Generally speaking, there are many different types of childhood injuries

and for different types of injuries, there are different types of interventions.

Table 15
Examples of programmes to prevent child injuries

Programme	Mode and content	Outcome
Community based programmes (Towner & Dowswell, 2002) ^v		
Community based injury prevention programme in Australia (Ozanne-Smith, Day, Stathakis, & Sherrard, 2002; Towner & Dowswell, 2002) (U) ⁱⁱⁱ	The Safe Living Programme targeted injury prevention in all settings using strategies such as programme publicity, education and training, injury hazard reduction and environmental change	QE population based evaluation using an intervention and comparison community design indicated no significant changes in rates of injury deaths, hospitalizations or emergency department presentations. Injury hazard reduction (> 50%) on the road, in schools, and to a limited extent, at homes (e.g. recommendations of playground and road audit enacted) was observed. Increased use of safety devices and equipment such as helmets, safety seats and smoke detectors was observed (HS) (IH)
Statewide child injury prevention programme (Towner & Dowswell, 2002) (U) ⁱⁱⁱ	A series of health promotion campaigns related to burns, poisoning, falls, suffocations, and passenger motor vehicle injuries with the target group being children under 5 years	There were 139 810 people in the 9 intervention communities and 146 866 in the 5 control communities. QE design study results indicated reduction in passenger motor vehicle injuries in intervention communities but no evidence was found in the reduction of other target injuries. Exposure to prevention messages was found to be associated with safety behaviour (HS) (IH)

^v Only evidences rated as “good” evidences are included in Table 15

Programme	Mode and content	Outcome
WHO safe community model (Lindqvist, Timpka, Schelp, & Risto, 2002) ^{iv} (U)	Provision of regular information about injury prevention to the general community, age adjusted safety information to parents at annual health visits, display of safety products and examples of modifications of risk environments at public areas, evaluation of indoor environment at daycare centres, schools and sports facilities, introduction of regular safety rounds for maintenance	QE design study results indicated more reduction of all-cause injury rate in the intervention area than in the control area (HS)
Safe kids/healthy neighbourhoods injury prevention programme in Harlem (Davidson et al., 1994) ^{iv} (U)	Repair and major capital improvement to parks and playgrounds, intensive pedestrian safety programme, traffic safety programme, dance programme, art studio, Little League programme, winter baseball clinic, soccer league, bicycle safety programmes	Time series design (?) study results indicated reduction in the overall injury rate among school aged children during the 3 years after the initiation of the programme, as compared with the rates 6 years before. Number of children studied: Intervention city – 26 818 in 1980 to 28 457 in 1990 Comparison city – 57 637 in 1980 to 66 305 in 1990 (HS)

Programme	Mode and content	Outcome
Home visit programmes		
Intervention package to reduce child injuries among children aged 3-12 months (Kendrick, Marsh, Fielding, & Miller, 1999) ^{iv} (U)	A package of safety advice at child health surveillance sessions at regular intervals, provision of low cost safety equipment (means tested), home safety checks and first aid training by health visitors	Cluster randomized controlled trial results (intervention group $n = 1\ 100$, control group $n = 1\ 019$) indicated that the intervention package was not effective in reducing the frequency of minor unintentional injuries in children at home (HS)
Pooled results of 8 home visit programmes (RCT) for the prevention of child injury (Roberts et al., 1996) (U) (S)	Antenatal and post-natal visit by health professionals and non-professionals for informational and emotional support. In 6 out of the 8 studies, the families were at risk families	RCT design ($n = 2\ 574$ from 8 studies) - lower incidence of injury in the home visit group versus control group - pooled odds ratio of 0.74 (95% confidence interval 0.60 to 0.92) (HS)
Preschool programme for safety and injury prevention by home visitors (Johnston, Britt, D'Ambrosio, Mueller, & Rivara, 2000) ^{iv} (S)	Home visit to Headstart families by trained school personnel. Intervention families ($n = 213$) were offered education materials, smoke detectors, batteries, ipecac, and car restraints based on home inspection. Comparison group ($n = 149$) families were only given written information	QE design study results indicated that intervention was associated with increased probability of having a working smoke detector, presence of ipecac in the home and obtaining car restraints at follow-up (IH)

Programme	Mode and content	Outcome
Home delivery of counselling and safety devices (Sznajder et al., 2003) ^{iv} (S)	Home visit by nurses and doctors when child was aged 6 to 9 months. Selection criteria included primipara, medical problem, psychological and/or socio-economic difficulties	Pre- and post- intervention results with no control group - percentage of home safety improvement was higher in group receiving counselling and safety devices ($n = 49$) than group receiving counselling only ($n = 50$) (IH)
Prenatal and infancy home visits (Kitzman et al., 1997) ^{iv} (S)	Home visits by nurses to families with at least 2 sociodemographic risk characteristics, including 7 prenatal home visits and 26 visits from child's birth to the child's second birthday	RCT results ($n = 1\ 139$) indicated that families visited by nurses reported fewer health care encounters for children in which injuries were detected and fewer days of injury-related hospitalization (HS)
Home-based intervention programme for maternal-infant attachment and child health (Armstrong, Fraser, Dadds, & Morris, 2000) ^{iv} (S)	Home visits to vulnerable families by child health nurses from birth to 3 months	RCT results indicated significantly fewer self-reported injuries and bruises in intervention group ($n = 80$) versus control group ($n = 80$) (HS)
Paediatric safety counselling and home visits for low income families (Gielen et al., 2002) ^{iv} (S)	Parents were given personalized education on home safety and opportunity to purchase reduced-cost products	RCT design study results indicated no significant differences in safety practices between parents receiving home visits ($n = 62$) and those who did not ($n = 60$) (IH)

Programme	Mode and content	Outcome
Home visiting programme for high risk pregnant women (Bablouzian, Freedman, Wolski, & Fried, 1997) ^{iv} (S)	Home safety assessment for high risk pregnant women, together with education about injury prevention practices and home safety supplies	Pre- and post- intervention measures - a significantly larger number of homes were assessed as safe at discharge from programme, compared with the initial assessment for use of child restraints, poison centre sticker on telephone, outlet plugs, safety latches on cabinets and drawers and ipecac at home (IH)
General practitioner safety advice for low income families (Clamp & Kendrick, 1998) ^{iv} (S)	Families were given safety advice and leaflets, access to purchase low-cost safety equipment, and home visit	RCT results indicated that intervention group families ($n = 83$) were more likely to use safety equipment including fireguards, smoke alarms, socket covers, locks on cabinets and door slam devices than control group families ($n = 82$) (IH)
Reduction of home hazards (Sullivan, Cole, Lie, & Twomey, 1990) ^{iv} (I)	Home safety assessment for children less than 6 years of age who were treated at a burn centre. Compliance with home safety recommendations after home visit was measured	The programme was found to have a positive effect on reducing home hazards (IH)

Programme	Mode and content	Outcome
Home visit to prevent childhood injury (King et al., 2001) ^{iv} (I)	Home visit to children less than 8 years old presenting to participating emergency departments, with parents in intervention group receiving an additional information package on injury prevention and discount coupons for safety devices	RCT results indicated no changes in parental injury awareness and knowledge. Significant changes favouring the intervention group (<i>n</i> = 601) were observed for adjustment of hot water temperature and smoke detectors (no information on working condition of smoke detectors). At 4 months, the intervention group tended to report fewer injury visits to the doctor, compared to the control group (<i>n</i> = 571) (HS) (IH) (HP)
Counselling		
Childhood injury prevention counselling in primary care settings (Bass et al., 1993) (U) (S)	7 RCT studies, 10 non-randomized, controlled studies and 3 multiple time series/descriptive studies	RCT studies – 5 demonstrated positive effects on knowledge or behaviours such as increased use of car seats, decreased hot tap water temperature QE design – all showed beneficial effects in preventing motor vehicle and non-motor vehicle injuries, with 3 showing decreased injury occurrence Multiple time series studies – significant gains in knowledge in one study and decrease in injury incidence in the other Descriptive study – significant gains in knowledge (HS) (IH) (HP)

10.6 Child abuse interventions for children

A meta-analysis of school sexual abuse victimization prevention programmes shows that these programmes are effective in teaching children self-protection skills and sexual abuse concepts. Programmes training self-protection skills are more effective than those on sexual abuse concepts. Preschool children can benefit from these programmes as well. However, effectiveness of transferring these skills and knowledge to real-life situation is not known (Rispen, Aleman, & Goudena, 1997). Developmental gains (e.g. changes in Bayley scores) are also observed for programmes for abused children but there are few follow-up studies and so the picture is not clear (Oates & Bross, 1995).

Table 16

Examples of child abuse programmes for preschool children

Programme	Mode and content	Outcome
Child sexual abuse victimization prevention programmes (Rispen et al., 1997) (U)	11 studies involving preschool children - knowledge of sexual abuse concepts and acquisition of self-protection skills were measured	QE design studies results indicated positive post-treatment scores in all studies, with programmes including explicit training in self-protection skills being more effective than programmes teaching sexual abuse concepts (IH) (HP)
Treatment of physically abused children (Oates & Bross, 1995) (I) ⁱⁱⁱ	Therapeutic preschools or day treatment programmes of varied approaches, including psychodynamic approach, developmental skills, cognitive skills and behaviour modification	RCT, QE and pre-post- test design studies indicated developmental gains or improvement in behaviour among treatment groups (HS)
Treatment of physically abused children (Oates & Bross, 1995) (I) ⁱⁱⁱ	Home – family therapy	QE design study results indicated that 74% treatment children remained at home but only 45% in the control group remained at home (HS)

Programme	Mode and content	Outcome
Treatment of physically abused children (Oates & Bross, 1995) (I) ⁱⁱⁱ	Residential setting – infant development programmes and parent counselling	One study (QE) showed little difference in developmental gains between controls and resident infants whereas in the other study (QE), residential infants surpassed control infants on interaction scales (HS)

10.7 Programmes to prevent/treat child abuse in parents

There are several reviews/meta-analyses on programmes to prevent/treat child abuse in parents (Guterman, 1999; MacLeod & Nelson, 2000; Nelson, Laurendeau, & Chamberland, 2001; MacMillan with the Canadian Task Force on Preventive Health Care, 2000). The reviews, in general, indicate that universal programmes are more effective than targeted (selective) programmes in preventing child abuse and neglect (Guterman, 1999). Larger effect sizes at follow-up than at post-intervention are observed for proactive (universal/selective) programmes but larger effect sizes at post-intervention than at follow-up are observed for reactive (indicated) programmes (MacLeod & Nelson, 2000) (see Table 18). Furthermore, the timing and length of the programmes are important and the more effective ones are those beginning at birth, lasting for several years and are more intensive. There is stronger evidence for home visitation programmes delivered by nurses for young, single mothers of low socio-economic status, beginning in the antenatal period and lasting until the child's second birthday. For families where child abuse is already a problem, cognitive-behavioural and behavioural approaches, and systems approach, such as systematic family therapy and behavioural family therapy are more promising approaches (MacDonald & Roberts, 1995). However, it is also recognized that child abuse is a complex problem and the nature of the family as well as the time of onset of the abuse are important factors in predicting response to treatment.

Table 17

Summary results of reviews of child abuse programmes for parents*

Programme	Mode and content	Outcome
Universal programmes (Guterman, 1999)	Early home visitation programmes (10 studies)	RCT and QE study results indicated improvement in parenting related measures (attitude or behaviour), and measures of child abuse (weighted mean effect size ^{vi} +0.092%) (HS) (IH) (HP)
Universal and selective programmes (MacLeod & Nelson, 2000)	Home visiting	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size ^{vii} = .378 Follow-up effect size = .493 (HS) (IH) (HP)
	Multi-component	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .470 Follow-up effect size = .581 (HS) (IH) (HP)

^{vi} Effect sizes for parenting parameters were calculated based on formulae using the Pearson Product Moment Correlation r statistics, which varies from -1.0 to 1.0. After the effect sizes of all individual studies were calculated, an aggregated weighted mean effect size was calculated, weighting each study effect size by the number of observations associated with each effect size (Guterman, 1999).

^{vii} Effect sizes were calculated by “subtracting the post-test mean of the comparison group from the post-test mean of the intervention group and dividing the result by the pooled standard deviation” (MacLeod & Nelson, 2000, p. 1133)

Programme	Mode and content	Outcome
	Social support/mutual aid	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .286 Follow-up effect size = .531 (HS) (IH) (HP)
	Media	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .125 (HS) (IH) (HP)
Selective programmes (Guterman, 1999)	Early home visitation programmes (4 studies)	RCT and QE study results indicated improvement in parenting related measures (attitude or behaviour), and measures of child abuse (weighted mean effect size +0.020%) (HS) (IH) (HP)
Indicated programmes (Macleod & Nelson, 2000)	Multi-component	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .406 Follow-up effect size = .219 (HS) (IH) (HP)

Programme	Mode and content	Outcome
	Social support/mutual aid	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .748 Follow-up effect size = .607 (HS) (IH) (HP)
	Parent training	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .357 Follow-up effect size = .246 (HS) (IH) (HP)
	Intensive Family Preservation Service	QE studies with outcome measures including child abuse, child placement, parenting attitudes and behaviour Post-intervention effect size = .500 Follow-up effect size = .350 (HS) (IH) (HP)

11. Cognitive domain

During the focus group discussions, many of the participants were concerned about the development of children from disadvantaged families such as lone parent families, new immigrant families, families where the mothers are in China, or low socio-economic status families. Examples of overseas programmes targeting children from disadvantaged families are listed below.

11.1 Educational interventions for children

Review of evaluation of early education interventions suggests that most of the programmes could demonstrate gains in educational achievement and cognitive skills immediately after the programme. However, the sustainability of the gains does

vary. The majority of these programmes are designed for children from disadvantaged backgrounds. Most of the reviewers conclude that parental involvement, age at which intervention begins, and duration or intensity of the programme are important factors contributing to the success of the programmes. In a Cochrane review of day care services, it is also found that out-of-home day care for children from disadvantaged backgrounds has beneficial effects on children's cognitive development and behaviour and in preventing school failure (Zoritch, Roberts, & Oakley, 2003). However, most of the programmes reviewed also contain elements of home visits and parenting education and it is not possible to separate the effects of these home/parent interventions from day care. Below are some examples of programmes which have been studied and implemented extensively.

Table 18

Examples of educational intervention programmes for children from disadvantaged families

Programme	Mode and content	Outcome
High/Scope Perry Preschool Programme (S)	Catering for children aged 3 to 4 from poor families. Programme includes classes for children (2.5 hours per day) and home visits (1.5 hours per week)	Using RCT design, the intervention group ($n = 58$) scored higher on intelligence tests between the ages 4 to 7, and again at ages 8, 9, 10, and 14. By the age of 15, more of the intervention group participants were still remaining in high school and they performed better academically than the control group ($n = 65$). At age 19, fewer intervention group participants were on welfare assistance and by age 27, there were fewer arrests in the intervention group (Schweinhart & Weikart, 1990 ^{iv} ; Webster-Stratton & Taylor, 2001). The cost-benefit analysis of the Perry Preschool Programme in USA suggests a return of US\$6.00 for every dollar spent on a one-year programme (Schweinhart & Weikart, 1988 ^{iv}). (HS)

Programme	Mode and content	Outcome
Abecedarian project (S)	Year-round educational child care from early infancy until kindergarten for children from high risk families	Using RCT design, it was found that the effects of the programme could be sustained at the age of 15. At the age of 15, more programme participants ($n = 57$) remained in high school and performed better academically than the control group participants ($n = 54$). Teen mothers of the programme participants also had an increased likelihood of high school completion and post-secondary training (Ramey et al., 2000 ^{iv}). The cost benefit analysis indicates that there is a benefit of US\$4.00 for every dollar invested (Masse & Barnett, 2003 ^{iv}). (HS)
Head Start (S)	Child and family development programme that served primarily low income children aged 3 to 5, combining day care with medical and dental treatment, social services and education for parents, emphasizing the child's psychological development and school readiness	QE design study results (based on 646 black children with data in three follow-ups) indicated immediate gains in cognitive ability, self-esteem, achievement motivation and social behaviour but results on the persistence of these effects were mixed (Lee, Brooks-Gunn, Schnur, & Liaw, 1990 ^{iv} ; Washington & Bailey, 1995 ^{iv}) (HS)

11.2 Children's educational enrichment programmes for parents

Though many of the parent-focused programmes (see section 14) may involve information on promoting children's cognitive development, there are few parent-focused programmes designed specifically for educational enrichment. Nonetheless, there are a few home visit programmes for children from disadvantaged backgrounds, or children who may have difficulties starting school, designed specifically with an education focus, and the evaluation results indicate positive

outcomes. These programmes use parents as home visitors, to be supplemented by group meetings.

Table 19

Examples of children educational enrichment programmes for parents

Programme	Mode and content	Outcome
Parents as teachers (S)	Home visits by paid parent educators, plus monthly group meetings	QE design with 380 families based on post-treatment status indicated positive effects on cognitive development at the age of 3 (Pfannenstiel, 1989 ^{iv}) (HS)
Home Instruction for Parents of Preschool Youngsters (HIPPY) (S)	Parents are taught to work with their children, using activity packets provided, through home visits by parent educators, supplemented by group meetings	In evaluation studies in New Zealand (77 HIPPY children and 704 non-HIPPY children of 6-year-old; 29 HIPPY children and 29 non-HIPPY children who had just entered school) and US (134 caregivers) using QE design based on post-intervention scores, HIPPY children performed better than their non-HIPPY classmates on achievement, behaviour academic self-esteem, school suspensions, and classroom behaviour (Monteith, Harre, & Field, 1999 ^{iv} ; Bradley & Gilkey, 2002 ^{iv}) (HS)

12. Social emotional domain

In chapter 3, the prevalence of behaviour problems in preschool children was estimated to be around 10% and there were also concerns about children's social skills. Programmes targeting children's behaviour and social skills are examined below.

The programmes discussed below (with the exception of Zippy's friends) are based on reviews of service for children by Buchanan (1999) and Webster-Stratton and Taylor (2001). The inclusion standards include: (i) availability of detailed scientific report on outcome; (ii) short and long-term effects demonstrated in a RCT; and (iii) availability of a manual describing the programme. Many of these programmes focus on problem-solving skills and social skills, and academic success skills are often included. Most of them are designed for children with conduct problems. It is found that classroom behaviour programmes targeting social behaviours and academic skills are effective in improving academic and social competence and reducing aggression. The programmes covering the preschool age range are summarized below.

Table 20
Examples of behaviour programmes for children

Programme	Mode and content	Outcome
I Can Problem Solve (ICPS) (Buchanan, 1999; Webster-Stratton and Taylor, 2001) (U) ⁱⁱⁱ	Whole classroom social skills training	Using RCT with 113 children in the intervention group and 106 in the control group, the results indicated that the intervention group children were less likely to show behaviour difficulties (HS)
High/Scope Perry Preschool Programme (Webster-Stratton and Taylor, 2001) (S) ⁱⁱⁱ	Classes for children from poor families aged 3 to 4, staff and parent training on child and parent skills, and home visits	Using RCT with 58 children in the intervention group and 65 in the control group, the results indicated fewer arrests in the intervention group at age 27, compared with the control group (HS)

Programme	Mode and content	Outcome
Programme for Academic Survival Skills (PASS) (Webster-Stratton and Taylor, 2001) (S) (I) ⁱⁱⁱ	A classroom consultant supported the teacher to develop a system of rewarding children for appropriate behaviour. Designed for children aged 4 to 9	Using RCT, the results indicated decrease in inappropriate behaviour (HS)
Contingencies for Learning Academic and Social Skills (CLASS) (Webster-Stratton and Taylor, 2001) (I) ⁱⁱⁱ	Individual child training by a consultant and supporting the teachers to develop a reward programme. Designed for disruptive children aged 4 to 6	Using RCT with 27 in the intervention group and 27 in the control group, the results indicated increase in appropriate behaviour (Hops et al., 1978) (HS)
Incredible years dinosaur curriculum (Webster-Stratton and Taylor, 2001) (I) ⁱⁱⁱ	A clinic-based programme for children aged 4 to 8 years old, presenting with conduct problems, training them in skills such as emotional literacy, stopping bullying, friendship skills, anger management, interpersonal problem solving and understanding school rules, and school success skills. Children met in small groups for two hours weekly for 22 weeks	Using RCT, with 97 children, the results indicated significant improvement in problem solving and conflict management skills (Webster-Stratton and Hammond, 1997) (IH)

Programme	Mode and content	Outcome
Zippy's friends (Partnership for children, 2004) ^{iv}	A 24 session programme designed for 6-year-old children, teaching them coping skills, skills in dealing with their feelings and prosocial behaviour	Using (?) quasi-experimental design, the experimental group consisted of 636 children in two countries and the control group consisted of 214 children in two countries. Based on teachers' observation and students' own evaluation, children used more positive coping strategies. There were improvements in social skills (teacher observation) and empathy (child interview). No information on comparison with control group was provided (IH)

13. Spiritual domain

In chapter 3, the stakeholders mentioned their concerns about values and morality. There are some overseas programmes targeting attitudes, values and motives. Many of them are targeted towards primary school children and adolescents and some are implemented within schools.

Table 21

Examples of programmes related to values and morality

Programme	Mode and content	Outcome
Child Development Project (Solomon, Battistich, Watson, Schaps, & Lewis, 2000) (U) ^{iv}	Promote student social, ethical and intellectual development through creating caring schools and classrooms Designed for primary and secondary school students	Using QE design, small to moderate positive changes in student attitudes, motives and behaviours were observed in high programme implementation schools compared with their comparison schools ($n = 1\ 970 - 2\ 105$). High programme implementation was measured using a composite index including researcher's observation and changes in teachers' attitudes (teacher questionnaire scores). (HP) (IH)
Building moral intelligence (Borba, 2001) (U) ^{iv}	A book written for parents with strategies/activities and self-evaluation scales to help them develop empathy, conscience, self-control, respect, kindness, tolerance and fairness in their children	No information was available on the psychometric properties of the self-evaluation scales and programme effectiveness. The author claimed that the strategies were research-based (HP) (IH)

14. Parenting issues

The importance of parenting education has been emphasized by many of the focus group participants and various surveys also indicated that Hong Kong parents were reporting considerable parenting stress. For overseas programmes, there are various types of parent-focused interventions. The target clients and the content also vary. Broadly speaking, the programmes include prenatal and infancy programmes for at risk pregnant women, and parenting programmes for parents of preschool or school children. Some of them are home visit programmes while others are centre-based programmes. The review below is mainly based on review reports of programmes involving RCTs (MacDonald & Roberts, 1995; Webster-Stratton & Taylor, 2001; Barlow, 1999) and a review of programmes by Zero to three (1999).

14.1 Prenatal and infancy programmes

These programmes involve nurses/trained staff visiting expectant mothers during the antenatal period until the children are one to two years old. There is a focus on mother-child relationship and the results indicate better mother-child relationship and maternal mental health. Most of the programmes are targeted towards at risk mothers. Below are examples of programmes which involve evaluation studies using control groups.

Table 22

Examples of prenatal and infancy programmes

Programme	Mode and content	Outcome
The prenatal/early infancy project (Olds, 1990) (S) ^{iv}	Preventing maternal and child health problems associated with poverty through nurses visiting parents regularly starting from the antenatal period until the infant was 24 months old. The content included prenatal education on mother's health and infancy education on child development. Informal support and linkages with other services were also encouraged	RCT ($n = 400$) results indicated a reduction in the incidence of child abuse and neglect among the intervention group participants (Olds, 1988) (HS)
The clinical nursing models project (Zero to three, 1999) (S)	Enhancing mothers' positive relationship with her child and other adults through regular visits by nurses from the second trimester of pregnancy to the end of the child's first year. Target clients were mothers who were at risk due to lack of social skills or social support	Using QE design (?), the results indicated that mothers in the intervention group showed less depression and had more positive interaction with their children than control group mothers who received only standard nursing follow-up (IH) (HS)

Programme	Mode and content	Outcome
Steps toward effective, enjoyable parenting (Project STEEP) (Zero to three, 1999) (S)	Facilitating healthy parent-infant relationship and preventing child social and emotional problems through regular visits by nurses from the second trimester of pregnancy to the end of the child's first year. Target clients were mothers who were at risk due to various reasons such as poverty, lack of education or youth	Using QE design (?), the results indicated that participants showed less depression and anxiety, better life management skills and understanding of their children's needs, and were more able to provide a stimulating environment than control group participants (HS) (IH)
The infant-parent program (Zero to three, 1999) (S)	Home-based assessment and intervention by trained staff	Using QE design (?) with Latino parent-infant dyads, the results indicated that these high-risk mothers were more empathic and interactive with their children, compared to the control group (IH)
UCLA family development project (Zero to three, 1999) (S)	Enhancing at-risk mothers' self-confidence, positive relationship with their children and other adults through regular visits by trained professionals from pregnancy to the first two years of the children's lives	RCT results indicated that participants showed improvement in adaptation, support system and mother-child relationship (IH)

14.2 Parenting programmes for parents of preschool children

There are a number of reviews on parenting programmes (Webster-Stratton & Taylor, 2001; Barlow, 1999; Barlow & Parsons, 2003; Barlow & Coren, 2003; Moore, Ochiltree, & Cann, 2001). However, each of the reviews adopts different criteria for programme selection (e.g. age range of children, availability of published manual, use of RCTs) and there is not much overlap in programmes covered in the reviews. Among all reviews, the general conclusion is that these parenting programmes are

effective in reducing child behaviour problems, with behaviourally-oriented programmes being more effective than humanistic programmes (Barlow, 1999). There are also indications that these programmes can lead to reduction in parental anxiety, depression, stress and marital conflict (Barlow, 1999; Barlow & Coren, 2003). Again, most of the programmes are designed for parents with children with conduct problems. Seven programmes for parents of preschool children have been included in at least two of the reviews and they are briefly summarized below.

Table 23

Examples of parenting programmes for parents with preschool children

Programme	Mode and content	Outcome
The Incredible Years (Webster-Stratton & Taylor, 2001; Barlow, 1999) (S) (I) ⁱⁱⁱ	Humanistic and behavioural group programme for parents of children aged 3 to 8 with conduct problems	Reduction in child behaviour problems immediately after programme and effect maintained at 1 year/3 year follow-up (RCT, various studies) (HS)
Coping Skills Parenting Programme (Webster-Stratton & Taylor, 2001; Barlow, 1999; Barlow & Coren, 2003) (S) ⁱⁱⁱ	Community-based group behavioural training for parents of children aged 2 to 5	Improvement in child behaviour and effect maintained at 6 months follow-up with 150 mothers of high-risk children over several studies (RCT) (HS)
Behavioural training programme (Sutton, 1992 ^{iv} ; Barlow, 1999; Barlow & Parsons, 2003) (I) ⁱⁱⁱ	Group behavioural training for parents of difficult preschool children	Improvement in child behaviour immediately after programme and effect maintained at 12/18 months follow-up with 41 parents of preschool children (RCT) (HS)
Helping the noncompliant child (Webster-Stratton & Taylor, 2001; Moore et al., 2001) (I) ⁱⁱⁱ	Individual parent skills training for parents of children aged 3 to 8 years, who were displaying noncompliant behaviours	Children showed decreased noncompliant behaviours and delinquency over several short-term and long-term effectiveness studies (RCT) (HS)

Programme	Mode and content	Outcome
Positive Parenting Programme (Sanders, 1999 ^{iv} ; Webster-Stratton & Taylor, 2001; Moore et al., 2001) (I) ⁱⁱⁱ	A multilevel programme including universal programmes for all parents to indicated programmes for parents with children with behaviour problems. The programme is based on social learning theories	Research, including RCTs, has consistently demonstrated significant improvement in family and child measures (HS)
Parental assistance programme (Scott & Stradling, 1987 ^{iv} ; Barlow, 1999; Barlow & Coren, 2003) (I) ⁱⁱⁱ	Group behaviour training for parents of children aged 2 to 14 with perceived behaviour problems	Improvement in perceived number and intensity of child behaviour problems and effect maintained at 1 year follow-up for 77 mothers studied. Significant decrease in parent depression (RCT) (HS)
Temperament-focused parent-training programme (Sheeber & Johnson, 1994 ^{iv} ; Barlow, 1999; Barlow & Coren, 2003) (I) ⁱⁱⁱ	Humanistic group parent training for mothers of 3 to 5-year-old children with difficult temperament	Improvement in child behaviour and gains maintained at 2 months follow-up. Significant decrease in parent depression and improvement in parent-child relationship with 40 mothers of 3 to 5 year-old children with difficult temperament (RCT) (HS)

15. Postnatal depression

There are different types of treatments. The major types include biological treatments (e.g. antidepressants and hormonal therapy), psychosocial treatments (e.g. individual counselling or psychotherapy and group treatment) and combined (biological and psychosocial) treatments (National Health and Medical Research Council, 2000). There is some limited evidence on the effectiveness of antidepressants with postnatal depression. However, there are concerns about the use of antidepressants in breast-feeding mothers (National Screening Committee,

2001; National Health and Medical Research Council, 2000; Scottish Intercollegiate Guidelines Network, 2002; Boath & Henshaw, 2001). For psychosocial treatments, there is some evidence to indicate that non-directive counselling by health professionals in primary health care settings, cognitive behaviour therapy and interpersonal therapy are effective in reducing mother's depression (Scottish Intercollegiate Guidelines Network, 2002; National Health and Medical Research Council, 2000; NSC, 2001; Cooper, Murray, Wilson & Romaniuk, 2003). There are very few studies on the effectiveness of group therapy (National Health and Medical Research Council, 2000). There was one study on the effectiveness of combined treatment but the study showed that there was no additional benefit by combining psychosocial treatment with biological treatment (National Screening Committee, 2001; National Health and Medical Research Council, 2000). There is no clear evidence on the effectiveness of prevention programmes (Scottish Intercollegiate Guidelines Network, 2002; NSC, 2001; Austin, 2003).

Table 24

Examples of prevention and intervention programmes for postnatal depression

Programme	Mode and content	Outcome
Prevention programme for at risk women (Austin, 2003) (S) ⁱⁱⁱ	Review of 5 studies offering structured and unstructured antenatal intervention to women identified as being at risk after screening programme	RCT and quasi RCT results with a total of 512 women indicated no clear evidence for reduction of postnatal depression through antenatal group intervention. (HS)
Oestrogen and progestogen for preventing and treating postnatal depression (Lawrie, Herxheimer, & Dalton, 2000) (I) ⁱⁱⁱ	Drug treatment given within 48 hours of delivery and lasting 8-12 weeks	RCT results indicated that depot norethisterone enanthate was associated with significantly higher postpartum depression scores than placebo. Oestrogen therapy in severely depressed women was associated with a greater improvement in depression scores than placebo (HS)

Programme	Mode and content	Outcome
Psychological treatment (Cooper, Murray, Wilson, & Romaniuk, 2003) (I) ^{iv}	Women with postnatal depression ($n = 193$) were randomly assigned to four conditions: routine primary care, non-directive counselling, cognitive-behavioural therapy or psychodynamic therapy	RCT results indicated that at 4.5 months, the three treatment groups reported lower depression scores than the control group (HS)
Fluoxetine and cognitive-behavioural counselling (Appleby, Warner, Whitton, & Faragher, 1997) (I) ^{iv}	87 women with postnatal depression were randomly assigned to four treatment cells: fluoxetine or placebo plus one or six sessions of counselling.	RCT (double blind) results indicated significant improvement in all four treatment groups. The improvement in subjects receiving fluoxetine was significantly greater than in those receiving placebo. The improvement after six sessions of counselling was significantly greater than after a single session. Interaction between counselling and fluoxetine was not statistically significant (HS)

16. Summary

Looking at the overseas programmes, it is obvious that parental involvement is important. It is also clear that programmes need to start early, even in the antenatal period. However, apart from some of the programmes in the physical and spiritual domains, most of the other overseas programmes are selective/indicated programmes targeted towards disadvantaged or at-risk families or children with conduct or learning problems, rather than primary prevention programmes at a community level. It should also be pointed out that different measures are used in the evaluation of programme outcomes.

In terms of evidence on the effectiveness of programmes, the picture is reasonably clear for parenting programmes (centre-based and home visit programmes) educational intervention programmes (children and parents), breastfeeding promotion programmes, oral health programmes, behaviour programmes for children and postnatal depression programmes where desirable changes are observed in parents and children. There is also evidence to indicate that child abuse preventive programmes in children and parents are effective. For programmes on obesity, nutrition, and injury prevention, the evidence is more mixed, and in different studies, different outcome measures are used. There is also limited evidence on the effectiveness of programmes on values and morality.

Summary and conclusion

In terms of the availability of effective programmes, for parenting programmes and child abuse prevention programmes, breastfeeding promotion programmes, oral health programmes, and postnatal depression intervention programmes, there are a fair number of overseas programmes which have been shown to be effective, including centre-based programmes and home visit programmes, though the majority of them (apart from breastfeeding and oral health promotion programmes) are selective/indicated programmes. Locally, some parenting programmes have also been shown to be effective. Further programme evaluation and development (both selective/indicated and universal programmes), or adaptation of effective overseas programmes to suit the local context should be considered.

For child behaviour programmes and educational intervention programmes directly involving at-risk children, there is little local information. The feasibility of adapting some of the overseas programmes which have been shown to be effective for local use could be considered.

For nutrition, obesity and injury prevention programmes, there is limited local information and the overseas results are mixed. Many of these overseas programmes employ multiple strategies. The feasibility of adapting the more effective overseas programmes for local use could be considered. There is limited evidence on the effectiveness of programmes on values and morality, whether local or overseas.

In terms of programme evaluation, in Hong Kong, programme evaluation activities are limited, and most of the evaluation activities are based on some forms of client satisfaction survey at the end of the programme. The issue of programme evaluation has not been emphasized by many stakeholders. However, to ensure that programmes are effective in meeting client needs, there is a strong need for programme evaluation activities. At the early stage when a new programme is being developed, the emphasis should be on experimental studies using rigorous research

design to test whether the programme can achieve the desired objectives under the best possible conditions. Once effective programmes are developed, there should be continuous evaluation and monitoring activities as means of quality assurance (Nutbeam, 1998). The Triple P evaluation and the establishment of the parent education database are promising steps towards rigorous programme evaluation.

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Chapter 6

Limitations

At this stage, it is important to point out the limitations of the present study. They are related to the scope of the study and the methodology.

Limitations of scope of the study

First, this study focuses only on children 0 to 5 and their families. The needs of children and adolescents aged 6 to 18 are not examined. This study could be regarded as a starting point in the needs assessment of Hong Kong children/adolescents.

Second, the focus of the present study is on the general population of children 0 to 5. In this study, while we have referred to special needs groups such as children from lone parent families, new immigrant families etc, detailed information about the well-being of these special needs groups has not been included. They will be the subject of further needs assessment studies.

Third, the information in this report is based on study reports, written documents or focus group discussions. No field studies have been conducted and the researchers do not have first hand experience or observations of the programmes described in the report.

Fourth, the present study is based on a search of literature in the health and social science fields. No policy analysis is involved. Furthermore, the views of policy makers in DH, SWD, EMB or other government departments/bureaux have not been sought.

Limitations of methodology

1. Quantitative data

The quantitative information collected is based mainly on routine data or official statistics and study reports through search of electronic databases or the internet.

First, it should be pointed out that the official statistics referred to in this report is a reflection of supply (what is actually provided), rather than need, as described in chapter 2.

Second, study reports which are not abstracted in the databases or uploaded on the internet might not be known to the researchers. While every effort has been made to search for study reports not abstracted in the databases, it is not possible to have knowledge of or have access to all relevant studies in the field. The study reports provide information on the extent (or prevalence) of problems (with variations in the representativeness of the sample), or the effectiveness of interventions. We

have provided information about the sampling method and participation rates in the studies as far as possible to help the reader judge the representativeness of the sample.

Third, there is also the issue of publication bias in the case of studies on the effectiveness of intervention programmes. Studies demonstrating programme effectiveness are more likely to be published than studies reporting no pre and post programme differences. The present review may have an over-representation of effective programmes.

Fourth, in the chapter on the effectiveness of programmes, there are few studies on the economic evaluation of overseas programmes. For local programmes, such information is lacking as well.

2. Qualitative data

First, it should be mentioned that while the qualitative data provides information about the issues of concern among the participating stakeholders, the data cannot tell us the extent or prevalence of the problem. The qualitative information is supplementary and complementary to the quantitative information. Though we have tried to recruit stakeholders from various sectors who are involved in the development of preschool children to attend the focus group discussions, we cannot claim that the sample is a representative one. It is possible that participants with strong views or concerns about the issues were more likely to volunteer to participate. Though we have included paediatricians in private practice in the focus groups, general practitioners were not included. The information so obtained and the conclusions arrived at should be interpreted bearing the above in mind. On the other hand, only themes which have been mentioned by a number of participants (the minimum number set was 10, being 1/10 of the sample) from at least two groups were included (unless otherwise specified). In the report, in each case, the sectors that have mentioned the themes have been described in the text so readers could judge whether the theme is a concern among participants across a number of sectors or specific to particular sectors.

Chapter 7

The Way Ahead

In this chapter, the issues and concerns identified in chapters 3 to 5, in relation to the current situation, services and programmes, will be discussed, to be followed by recommendations for future actions. The basic principles and strategies for service provision are also outlined.

Before discussing the principles and strategies for intervention, the definition of health (as discussed in chapter 3) and the basic principles of development (discussed in chapter 1) are re-iterated here. According to the WHO, health is “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (WHO, 1948, p. 100). Health is “a resource for everyday life, not the objective of living” (WHO, 1986, p.1). Apart from social, mental and physical aspects, the concept may be broadened and optimal health can be defined as “balance of physical, emotional, spiritual, intellectual and social health” (O’Donnell, 1989, p. 5). In terms of human development, this study adopts a *holistic view* emphasizing links across multiple domains of development, i.e. physical, cognitive, social emotional and spiritual (O’Donnell, 1989). Developmental tasks or issues are conceptualised as being broadly integrative, cutting across the various domains (Sroufe & Rutter, 1984). Furthermore, development is viewed from an *ecological framework* (Bronfenbrenner, 1979, 1989; Buchanan, 2000), which sees a child’s development as being shaped by the interaction of both nature and nurture, including the child’s biogenetic makeup, his/her experiences, interactions with others in the family and the physical and social environment. These biological and environmental influences may act as risk or protective factors. Finally, a *lifespan perspective* is used. It is recognized that development continues into the adult years. Experiences are programmed into the functioning and structure of the individual’s biological and behavioural systems. Early experiences impact on later life outcomes and there are changes in functional status over time (Halfon & Hochstein, 2002).

Principles and strategies for intervention

In planning for intervention, it is recognized that *prevention* is a potentially more cost-effective strategy to reduce the impact of child health problems on the individual and the community, provided that these interventions are evidence-based (Hawkins, 1999). The emphasis on prevention and evidence-based practice has guided our review of effective programmes in chapter 5 and they will also be the underlying principles in our discussion on service provision in the following sections. At this stage, it is, however, useful to distinguish between four levels of prevention measures

(Last, 2001). *Primordial prevention* consists of “actions and measures that inhibit the emergence and establishment of environmental, economic, social and behavioural conditions, cultural patterns of living, etc., known to increase the risk of disease” (Last, 2001, p. 141). This is in the realm of health promotion, involving especially public health policy. *Primary prevention* is essentially a public health strategy of decreasing the occurrence of disorders for the population as a whole (population approach), as well as specifically for groups at higher risk (high risk approach) (Rose, 1992). *Secondary prevention* is the arena of preventive measures whose purpose is to control the disorders and to minimize disabilities through early identification and prompt intervention. The availability of valid screening tools for early identification and adequate resources for confirmation of diagnosis and intervention are pre-requisites for an effective secondary prevention programme (e.g. a screening programme). It is recommended that before a screening programme for a condition is initiated, “all cost-effective primary prevention intervention should have been implemented as far as possible” (National Screening Committee, 2001, p. 2). *Tertiary prevention* is the task of rehabilitation where measures are taken to reduce the impact of and minimize suffering caused by long-term disorders and disabilities. It is reckoned that primordial and primary prevention should be emphasized as these measures are likely to be more effective and less costly than intervention at a later stage (Patterson et al., 2002).

Consistent with the ecological framework described in chapter 1, it is recognized that an individual’s health and well-being are determined by *multiple determinants*, which include not only the individual’s biogenetic make-up (that is largely un-modifiable), the individual’s own action or behaviour, but also wider influences of the social, economic, cultural and physical environment. Some of these determinants (e.g. individual health behaviours) may be within the individual’s control, but others are outside one’s own control (e.g. economic conditions). Thus, a fundamental principle in promoting child health and well-being is that multiple determinants should be targeted.

To address the multiple determinants and to empower the individual to take control of his or her own behaviour and environment, the concept of health promotion, which is related to primordial prevention, is relevant. *Health promotion* “is the process of enabling people to increase control over, and to improve, their health” (WHO, 1986, p. 1). The Ottawa Charter for Health Promotion (WHO, 1986) promulgates five health promotion strategies. First, *building healthy public policy* includes legislation, fiscal and tax policies, organization changes, and coordinated joint actions. Second, *creating supportive environments* involves generating safe, stimulating, satisfying and enjoyable living and working conditions. Third,

strengthening community actions involves empowering communities so that they own and control their own endeavours and destinies. Fourth, *developing personal skills* includes supporting personal and social development through provision of information, health education and life skills enhancement. The aim is to increase people's options in exercising control over their own health, their own environment, and to make informed choices conducive to their own health. Fifth, *reorienting health services* means that health services should embrace an expanded mandate that focuses on the total needs of the individual as a whole person, rather than just providing clinical and curative services. This also requires attention to health research and changes in professional education and training. Analyses of successes in health promotion programmes indicate that interventions to persuade people to change their lifestyles or health behaviour are not useful in the absence of "actions to change the environment and the institutions that shape people's choices" (Nutbeam & Wise, 2002, p. 1880). *Multifaceted strategies* are therefore recommended in health promotion programmesⁱ.

To target the multiple determinants in a co-ordinated way, a comprehensive approach to health development (WHO, 1998) is needed. This approach calls for *multi-sectoral collaboration* (Nutbeam & Wise, 2002) and *multi-agency collaboration*, to produce an integrated and comprehensive service. Integration of services is also vitally important in reducing gaps or overlaps or inconsistencies in services and programmes. The concepts of "*joined up government*" and "*cross-cutting*" are becoming more popular and child health initiatives such as the Sure Start in U.K. is an initiative which pulls together the education, health and welfare sectors (Glass, 1999; Roberts & Hall, 2000). The essential idea of joined up government is "to seek to re-engineer governance processes so as genuinely to reunify or re-orientate them to meet the needs of the client groups being served. Ideally, joining up should make the governance process as simple and transparent as possible instead of citizens or organizations having to deal on connected issues with a maze of different agencies. It also means establishing unified cross-departmental programmes, with integrated spending budgets" (The United Kingdom Parliament, 2001, para 6). To achieve joined up governments, a cross-cutting approach is needed. Cross-cutting can take many different forms including "merged structures and budgets, joint teams (real or virtual), joint customer interface arrangements, joint management arrangements,

ⁱ For example, in tobacco control programmes, the components include education and information (e.g. warning labels), regulatory and legislative measures (e.g. advertising and promotion bans), economic measures (e.g. price increases in cigarettes), cessations (e.g. cessations programmes), crop substitution and diversification advocacy (e.g. advocacy for policy change), and administration and management (e.g. co-ordination of programme components) (Asma et al., 2002).

sharing information” etc (Cabinet Office, 2000, p. 16). The issues of collaboration, integration and interface among these sectors will be further discussed in the following sections.

The WHO, in its 1997 Jakarta Conference, also recognizes that *settings for health* (such as “health promoting schools”, “health promoting families”) offer practical opportunities for the implementation of health programmes (WHO, 1998). Making settings of social life and activities such as preschool, workplace, home and neighbourhood more conducive to health could provide great opportunities for health promotion. This approach will be further described below.

Finally, as mentioned before, services and programmes should be *evidence-based*. *Evaluation* of the effectiveness of the programme outcome and *quality management* should be conducted. Both the provider and the consumer would need to know that the programmes and services are meeting the needs of the consumers and are achieving their defined objectives (Nutbeam, 1998). Examples of models of health promotion planning and evaluation include Nutbeam’s (1998) outcome model for health promotion and the six-stage development model for the evaluation of health promotion programmes, as well as the Framework for Integrating Theories and Models for Community Health Promotion by Best et al. (2003).

Types of recommendations

As stated above, the challenges in promoting the well-being of preschool children are multifaceted (Guy, 1997). Multiple determinants are to be targeted and multiple strategies need to be in place. Some of these determinants may be amenable to changes through individual level programmes, involving mainly service providers and professionals, at the operational level. Others may be related to structural society issues which require strategic planning and policy changes at the national level, with the commitment and leadership from high ranking government officials and policy makers. While it is recognized that such strategic policy changes are essential to create a supportive environment for individual behavioural changes, the actions and recommendations that can be implemented at the professional operational level, are also indispensable. In the sections below, recommendations are listed under two categories, recommendations that involve mainly service providers and professionals at the operational level, and recommendations requiring the commitment and leadership from high ranking government officials and policy makers.

Operational level recommendations

1. Child and family public health needs

As stated in chapter 2, “health needs assessment is a systematic method of identifying unmet health and health care needs of a population and making changes to meet these unmet needs” (Wright, 2001, p.38). In the previous chapters, we have identified problem areas (chapter 3) and examined the effectiveness of existing programmes in dealing with these problems (chapter 5). This was done through search of literature on the local situation, as well as local and overseas programmes, together with focus group discussion with stakeholders including preschool workers, health professionals, academics and parents. In the following section, the needs of preschool children and their families are discussed based on (i) the problem area identified (and the extent of the problem if possible); (ii) the availability of effective intervention; and (iii) the current provision of service. Recommendations will be made in respect of (i) identified gaps in information, (ii) identified gaps in service provision and (iii) identified gaps in the evidence-based interventions.

1.1 Clear indication of prevalence of problems, and availability of effective programmes

1.1.1 Child behaviour problems and parenting difficulties

Local surveys estimate that about 10% of preschool children are displaying behaviour problems. Stakeholders are unanimously concerned about the lack of social skills among preschool children. Closely related to the issue of child behaviour problems is the issue of parenting. From various surveys, it is quite clear that parents in Hong Kong are reporting difficulties in parenting and parenting stress. This issue has also been pointed out by stakeholders in focus groups. Parenting problems are seen as one of the major causes of child behaviour problems. However, the lack of valid local instruments on child social behaviour and the lack of local norms for parenting practices and difficulties make it difficult to get a clear picture of the prevalence of these issues among preschool children and their families.

Research evidence on overseas child behaviour programmes (working directly with children) demonstrates the effectiveness of such programmes in reducing child behaviour problems, including social difficulties. There is not much information on local child behaviour programmes. As many of the effective overseas programmes are implemented in classrooms, professional input and support for preschool teachers will be needed for their implementation in Hong Kong. With local kindergartens being privately owned, there might be considerable difficulties in funding the professional support and input needed for the success of these programmes, though this maybe more viable for kindergartens/day nurseries operated by NGOs with their

own team of psychologists.

Research evidence on overseas parenting education programmes has clearly demonstrated their effectiveness in terms of decreasing problem child behaviours and parental stress, among at risk groups (selective programmes), but there is less information on the effectiveness of universal programmes. There are also locally conducted/developed parenting education programmes. Some of them have been evaluated using randomized controlled trials or other quasi-experimental designs and the results are encouraging. Some of them are for parents who are experiencing problems in parenting (indicated programmes) and others are for all interested parents (universal programmes).

In terms of current provisions, MCHCs and NGOs are the major providers of parenting education programmes in Hong Kong. In MCHCs, parenting education for parents of preschool children has been implemented in phases since September 2002. Full implementation is expected to be achieved by mid 2004. Parent support groups cum parenting programmes in MCHCs are being piloted, in collaboration with SWD. There are also parenting education programmes conducted by the social service sectors, some of which are targeted towards parents of preschool children.

Given the difficulties in implementing child behaviour programmes in preschools as discussed above, for the time being, it is sensible to focus on parenting education programmes which have been shown to be effective in reducing child behaviour problems (see chapter 5, section 14.2 for details). However, the option of preschool-based child behaviour programmes should also be explored, as this will, in the long run, develop and enhance the skills of preschool workers in managing child behaviour problems. Furthermore, some social skills related issues are more likely to occur in the preschool setting, where there are peers, than at home, given that there are a fair number of households with only one child (see chapter 3, section 8).

The following recommendations are made:

- Parenting education should continue to be promoted and developed. Both universal and indicated programmes (targeted at parents with children with behaviour problems or parents with parenting difficulties) should be promoted and developed. New parents and parents-to-be should be encouraged to attend parenting programmes.
- Preschools (including parent-teacher associations), and MCHCs (including ante-natal classes) should continue to be used as venues for delivering parenting education.
- There is a need to train parent leaders to have the knowledge and skills to work for parent-teacher associations.
- The option of preschool-based child behaviour intervention programmes should

be explored.

- The behaviour management skills component should be strengthened in training courses for preschool teachers.
- Development of valid local instruments to measure child social behaviour and local norms for parenting issues should be explored (see also section 1.5).

1.1.2 Breastfeeding

The breastfeeding rate in Hong Kong is still behind international rates. It is recognized that effective interventions should be long-term and intensive, and include a combination of mother and baby friendly policies; information to pregnant women, breastfeeding mothers and families; and competent guidance and support by health professionals.

The following recommendations are made:

- A high level multi-sectoral breastfeeding committee with representatives from relevant government departments, NGOs, and health professional associations should be established (UNICEF/WHO, 1990).
- More support for sustaining breastfeeding through staff, volunteers and hotline should be explored. Home visits should be considered.
- The possibility of re-cycling and lease of breastfeeding equipments for needy families could be explored.
- There should be more publicity on available breastfeeding resources.
- There should be more public education about breastfeeding.
- Availability of suitable places for breastfeeding in public venues and workplaces should be promoted.

1.1.3 Oral health

The dmft values of Hong Kong children are not as good as those of other developed countries. Research shows that community oral education programmes are effective in reducing dental caries, with most of the programmes for young children involving their parents. Locally, there are pilot oral health programmes in MCHCs and preschools.

The following recommendations are made:

- The DH oral health promotion programme being piloted in MCHC, if found to be effective, should be extended to all MCHCs.
- The DH oral health promotion programme in preschools should be further promoted.

1.1.4 Postnatal depression

It is estimated that about 12% of Hong Kong women are affected by postnatal depression. There is some limited evidence on the effectiveness of antidepressants, as well as non-directive counselling by health professionals and psychotherapy. There is a need for more co-ordination between the HA, DH and NGOs in the effective identification and management of these postnatal mothers.

The following recommendation is made:

- Research on the effectiveness of treatment and the outcomes of screening in the local context should be conducted.

1.1.5 Child abuse

Though there is official statistics on child abuse cases, as discussed before, the official figures are likely to be underestimations of the actual situation as there is no mandatory reporting of child abuse cases in Hong Kong. However, other surveys indicate that the incidence of physical abuse is higher in Hong Kong, when compared with western countries. Information on forms of abuse other than physical abuse is relatively scarce.

The overseas literature also indicates that there are effective child abuse prevention programmes for parents. Some of the prenatal and early infancy programmes discussed under the parenting education heading have been shown to be effective in enhancing parent-child relationship and they may also be regarded as child abuse prevention programmes. Preventive programmes for children have also been shown to be effective. However, the evidence on intervention programmes for at risk families is more limited though there are indications that cognitive-behaviourist, and behavioural approaches, and systems programmes are effective. The Committee on Child Abuse (CCA), chaired by the Director of Social Welfare and comprising representatives from concerned government bureaux/departments, professionals and NGOs, will continue to work closely to devise strategies to tackle the problems of child abuse through multidisciplinary approach.

The following recommendation is made:

- The issue of child abuse, both in terms of prevention and treatment, should continue to be monitored by the multi-sectoral committee chaired by the Director of Social Welfare.

1.2 Some indications of prevalence of problems, and availability of effective programmes

1.2.1 Lifestyle issues

Various survey results, in one way or the other, indicate that the dietary habits of Hong Kong preschool children are low in fruit and vegetable intake and their physical activity levels are low. In the focus group discussions, stakeholders have also voiced the same concerns about nutrition, obesity and lack of physical exercises.

Evidence on the effectiveness of overseas programmes is mixed, and different outcome measures are used in different evaluation studies. The limited information suggests that while the programmes are effective in changing health knowledge, the effect on health behaviour is mixed.

Locally, a dietary survey of children aged 0 to 5 from MCHCs has been conducted in 2003 and the results will be forthcoming. More information about the level of physical activities of preschool children is required. Currently, parents are given information on nutrition and physical exercises through the parenting programme in MCHCs. Nonetheless, there is a need for effective public health programmes to promote healthy eating behaviour and regular physical exercises in young children.

The following recommendations are made:

- More comprehensive information on diet and physical activities should be collected.
- There should be safe outdoor and indoor play facilities for children, such as playground and game room.
- Effective programmes to promote healthy eating behaviour and regular physical exercise should be developed. These should include guidance to parents/caregivers and the preschool setting is an appropriate setting for health promotion.

1.2.2 Childhood injuries

Though the Hong Kong mortality rate due to childhood injuries is lower than overseas rates, being one of the most preventable health issues, further work in this area is indicated. In relation to effective programmes, positive outcomes are reported in most overseas programmes, though the outcome measures vary tremendously depending on the type of injury to be prevented and the context. Locally, parents are given information on home safety through the parenting programme in MCHCs. Home visit programmes for families with history of unintentional injury in children were piloted and evaluated by the Hong Kong Childhood Injury Prevention and Research Association.

The following recommendation is made:

- There should be further development and evaluation of home injury prevention programmes in the local context.

1.3 Some indications of problem but little information available

It was pointed out in the focus group discussion that spiritual issues such as respect for others, social connectedness etc. should be promoted. There is also some indication that various aspects in the spirituality domain are below the basic performance standard among primary and secondary students (Pang, Wong, & Leung, 2002). However, different definitions are used and there is no consensus on the definition of spirituality. Without a consensus on its definition, it is not possible to develop measurement tools or indicators or develop programmes to promote spirituality.

The following recommendation is made:

- A working group should be set up to come to a working definition of spirituality.

1.4 Inter-disciplinary and inter-sectoral collaboration

At present, in Hong Kong, service provision to preschool children and their families are separately provided by the health, education and social service sectors. The issue of service interface has been mentioned by all stakeholders and the consensus is towards integrated community-based services for preschool children and their families. As mentioned earlier, settings for health (such as “health promoting preschools”, “health promoting homes”) offer practical opportunities for the implementation of health programmes. Making settings of social life and activities such as preschools conducive to health could provide great opportunities for health promotion. In overseas countries such as Canada, there is increasing emphasis on collaboration among schools, parents and communities in making the school a focal point for promoting the well-being of children (Guy, 1997). The concept of health promoting schools is becoming popular. A health promoting preschool programme adopts a whole school approach, and aims to support schools in becoming safe, happy and healthy places in which to work and learn. The programme looks at the curriculum, the school policies, practices and environment and the links between school, home and community so that they all work together for the best possible health outcomes.

The following recommendations are made:

- A good entry point for service integration for children 0 to 3 is the MCHC. The existing services can be enriched by integration with services provided by SWD and NGOs. A new model for integrated services can be explored and developed.

There should be inbuilt evaluation mechanisms to evaluate the effectiveness of the model.

- For children aged 3 to 5, it is recommended that a pilot health promoting preschool programme should be set up. Evaluation mechanisms should be built into the pilot project.

1.5 Establishment of a set of health indicators

Keeping track of how well a society is doing in promoting child wellbeing is important (Guy, 1997). Establishment of a set of indicators of child well-being and tracking these measures can inform us what is going right and what is going wrong with our preschool children. In national reports on the well-being of children in Australia, Canada, U.K. and U.S.A. (Australian Institute of Health and Welfare, 2002; Canadian Institute of Child Health, 2001; Federal Interagency Forum on Child and Family Statistics, 2003; Rigby & Köhler, 2002; Office for National Statistics, 2000), there is a clear set of carefully developed indicators for each country which are developed by a panel of experts in the area of child health (Australian Institute of Health and Welfare, 2002; Canadian Institute of Child Health, 2001; Federal Interagency Forum on Child and Family Statistics, 2003; Rigby & Köhler, 2002). A summary of the major indicators relevant to preschool children adopted by Australia, Canada, European Union, U.K. and U.S.A. can be found in Appendix 4.

Locally, the need to establish a set of health indicators has been raised in the focus groups. Ideally, the set of health indicators should include all health dimensions, viz. physical, cognitive, social emotional, and spiritual. Regular population data on these health indicators could be collected and collated and this will provide the necessary information for comparison across family groups and times. The information will also be useful in service planning and the evaluation of the effectiveness of programmes and services.

The DH Public Health Information System is a major initiative announced at the Chief Executive's 1998 Policy Address. It serves to collect, collate, analyse and disseminate health information. From Appendix 4, it can be seen that there are available local indicators in the physical domain, but local indicators in the cognitive (reading), social/behaviour, spiritual and family (parenting) domains are lacking.

The following recommendation is made:

- To search for or develop suitable and valid local indicators in the cognitive domain (reading), child social/behavioural domain, spiritual domain (after consensus on its definition is achieved, see section 1.3) and parenting issues.

1.6 Programme evaluation

Increasingly, in service provision, a *focus on outcome* is being stressed. Being able to demonstrate the differences that various programmes make to child well-being is important. Programme evaluation should be encouraged and promoted (Guy, 1997). In Hong Kong, though major service reviews are commissioned and quality assurance and monitoring procedures are in place for many programmes or services, rigorous evaluation activities are still limited. The majority of programmes are evaluated using client satisfaction questionnaires. As mentioned in chapter 5, at the early stage when a new programme is being developed, studies using rigorous research design to test the efficacy of the programme should be used as far as possible. This can then be followed by testing in the field situation to establish the effectiveness of the programme. Once effective programmes are developed, there should be continuous evaluation and monitoring activities as means to quality assurance (Nutbeam, 1998).

The following recommendations are made:

- There should be rigorous research to establish the effectiveness of local programmes before their launching.
- There should be evaluation of ongoing programmes and quality management measures instituted, as necessary, to ensure that the objectives of the programmes are met.
- Training on research methods and programme evaluation should form part of professional training and in-service professional development.
- The DH Triple P database and parent education database could serve as an interim platform to support the evaluation of parenting education programmes.

1.7 Needs assessment on special groups

During the focus group discussions, stakeholders are concerned about the well-being of preschool children in lone parent families, new immigrant families, and families where the mothers are in mainland China. There is also concern about the needs of children with developmental problems. In addition, the needs of ethnic minority children should not be overlooked. Overseas research indicates that there are effective educational enrichment programmes for at risk children and children from disadvantaged backgrounds. However, without more information about the specific needs of local children and their families, it is not possible to decide what the best services for them are.

The following recommendations are made:

- Needs assessment be conducted for preschool children from lone parent families, new immigrant families, ethnic minority families, families where the mothers are in mainland China, and families with socio-economic disadvantage.

- Needs assessment be conducted for preschool children with developmental problems.

Policy level recommendations

2. Government policy and co-ordination

For health promotion actions to be effective, as mentioned before, there is a need to address the multiple determinants of health and it is often necessary to change the environment and the institutions that shape people's choices. However, it is impossible for one single government department to target the multi-determinants and coordinate team work right across the government (Cabinet Office, 2000). Government leadership is required in policy formulation and implementation to alter the structural environment that shapes people's choice, as well as to co-ordinate teamwork across various agencies, sectors, and government departments/bureaux.

Furthermore, as one of the signatories to the United Nations Convention on the Rights of the Child, it is important for Hong Kong to fulfil its obligations under the Convention. The UNICEF encourages signatory country governments to develop a comprehensive national agenda for children and to develop permanent organizations or mechanisms to promote co-ordination, monitoring and evaluation of programmes throughout all government sectors (UNICEF, n.d.). To formulate a national agenda for children and to promote co-ordination of various activities throughout all sectors, active government leadership, joining-up of government departments and non-government sectors, and development of permanent organizations on child well-being are important.

Signatory countries to the United Nations Convention on the Rights of the Child such as Australia, Canada and United Kingdom have developed national policies and programmes on children's well-being. Often, the idea of joined up government is central to these policies and there are ministers for children. For example, in United Kingdom, a Children Bill is being introduced in the House of the Lords on 3 March 2004 (House of Lords House of Commons Joint Committee on Human Rights, 2003; The United Kingdom Parliament, 2004), to "make provision for the establishment of a Children's Commissioner; to make provision about services provided to and for children and young people by local authorities and other persons; to make provision in relation to Wales about advisory and support services relating to family proceedings; to make provision about private fostering, child minding and day care, adoption review panels, the making of grants as respects children and families and about child safety orders" (House of Lords, 2004, p.1). The post of Director of Children's Services, accountable for children's services, is to be appointed within local children's services authority. A new Minister for Children, Young People and

Families, within the Department of Education and Skills, has been created to coordinate policies across governments (Crown Copyright, 2003; Department for Education and Skills, 2004). The Sure Start Programme in United Kingdom is an initiative to put into practice the “joined up thinking” by pulling together health, education and welfare services for children aged 0 to 3 years in a coordinated way (Glass, 1999; Roberts & Hall, 2000). The programme aims to provide better childcare, free nursery education place for all three year old children, and better health and family support. A Sure Start unit is established in the Department for Education and Skills and Department for Work and Pensions and the unit is led by the Minister for Sure Start (Sure Start, 2003). In Australia, there is a Minister for Children and Youth Affairs and a National Agenda for Early Childhood is being developed (Commonwealth of Australia, 2004; Australian Government Department of Family and Community Services, 2004). In Taiwan, children’s welfare is under the Child Welfare Bureau of the Ministry of the Interior (Child Welfare Bureau, Ministry of the Interior, R.O.C., 2002). In Canada, the National Children’s Agenda has grown out of discussions by federal, provincial and territorial health and social services areas (UNICEF Canada, n.d.). It is recognized that no single organization can meet all the needs of children and there is strength in working together, to ensure that there are no gaps or duplications (National Children’s Agenda, 1998).

In Hong Kong, stakeholders are of the view that our society should invest on preschool children and their families so as to create a better future for the whole society. The government needs to have a clear policy to safeguard and promote the well-being of children aged 0-5 and their families. Formulation of child policies and family-friendly policies to provide a supportive environment that shapes people’s choices has been suggested.

At present, the main sectors involved in the provision of health, education and social services for children are in the public, private and non-government sectors. It is however recognized that there are other government bureaux/departments who are also involved in service provision to preschool children. For example, provision of library and playground facilities for preschool children fall within the remit of the Home Affairs Bureau and Leisure and Cultural Services Department. Collective policies and joint actions among these government bureaux and departments, the non-government and even the private sectors are essential in providing an integrated service. The establishment of a central body such as a Children’s Commission to co-ordinate collective policies and joint actions is considered a viable option.

The following recommendations are made:

- The creation of a family-friendly environment to support parents in performing their parenting roles more effectively is important to the healthy development of

preschool children. Family-friendly policies to support and promote child and family well-being should be considered.

- The Government should consider taking the leadership role in various areas of early childhood provision, notably in the areas of early childhood education and quality assurance of child-minders and tutors in the after-school interest classes.
- Joining up of government bureaux/departments in the formulation and implementation of child and family policies to promote child and family well-being. The establishment of a Children's Commission could be considered.

3. Evidence-based policies

Policies for promoting child and family well-being should be evidence-based. Sanderson (2002) lists several ways in which evidence can inform policy development and implementation. First, evidence of problems and needs requiring policy action is required. In this report, we have sought to examine the current state of well-being of preschool children and their families, and identify problems and needs. Second, evidence of the likely effectiveness of policy options is required to inform decisions on the policy actions to be taken. This fits well with a rational decision-making model and policy is seen as a purposive course of action to achieve certain objectives. The action taken is based on a "careful assessment of alternative ways of achieving such objectives and effective implementation of the selected course of action" (p. 5). While the present study has examined the effectiveness of various programmes, the study has not been able to examine evidence of likely effectiveness of policy options. This kind of research, however, is needed to inform decisions on policy actions.

In order to identify the multi-determinants of health and the antecedents of child health and development, longitudinal research is important. The National Longitudinal Survey of Youth and Children in Canada (Human Resources Development Canada, 2002) and the Avon Longitudinal Study of Parents and Children (ALSPAC) in U.K. (Golding, Pembrey, Jones, & the ALSPAC Team, 2001, p. 75) are examples of longitudinal studies on factors influencing child health and development. These researches can serve to increase understanding of the extent and nature of child health problems and children's needs, and to provide information on the likely effectiveness of policy actions.

Third, evidence from the evaluation of policy implementation is also important to inform decisions on the continuation or discontinuation of policies or any adjustments needed (Sanderson, 2002). It is suggested that new policy initiatives should be subject to pilot trials or prototyping before they are being implemented on a

national level. For example, with the Sure Start initiative mentioned before, there were pilot programmes and evaluation against a set of agreed indicators.

The following recommendations are made:

- Careful examination of the evidence of the likely effectiveness of potential policy actions should be conducted before decisions on policies are made.
- To inform the development and implementation of policies on child well-being, large scale longitudinal studies addressing the multi-determinants of child development in the local context are needed. Among many others, potential areas could include the impact of parental employment on parent-child relationship, the impact of education experience (e.g. enrichment classes) and mass media on the social, cognitive and cultural development of children.
- New policy initiatives should be subject to pilot trials and be evaluated against a set of agreed indicators.

Setting priorities

In chapter 1, we have reviewed the literature, arguing for the importance of the early years. The literature confirms the need to promote the optimal development of children, through protecting the child from harm and providing all the child needs for optimal growth and development, which include not only bodily needs but more importantly, caring and loving relationships. The parents or caregivers, as the primary socializing agents for children, play an important role in this aspect. Nurturing and trusting relationships beyond the early years and opportunity for life-long learning are also essential for continuous optimal development of the person. Early intervention programmes for at risk children are needed to address their plight and change the unfavourable trajectory.

In this chapter, recommendations are made, based on an examination of the current well-being of Hong Kong preschool children and their families, current services, and effectiveness of intervention programmes. As there are a fair number of recommendations, some of which need to be in place before others can be implemented, it is necessary to set priorities for their implementation to provide direction and to ensure that the implementation is organized and co-ordinated.

At the conceptual level, what is lacking is a *consensus on what spirituality is*. Without a consensus on its definition, development of measurement tools and intervention programmes are not possible.

To ensure that programmes are tailored to the specific needs of different groups of preschool children and their families, *needs assessment* is a prerequisite for service planning. This report describes the general needs of children 0 to 5 years. Further needs assessment for special groups should be conducted to understand their specific

needs. The availability of *valid local indicators and measurement tools* makes important contributions to needs assessment. Development of these should therefore be considered a priority. On service provision, as indicated in chapter 4 and sections 1.1 and 1.2 of this chapter, many of the intervention and education programmes for preschool children and their families are already in place and these should continue to be provided and developed. Nonetheless, rigorous *programme evaluation and quality assurance* are extremely important in ensuring that programmes and services offered are effective in meeting the needs of preschool children and their families and are of high standards. All service providers should strive to build evaluation and quality assurance mechanisms into all programmes. Last but not the least, *inter-sectoral collaboration* is vital in ensuring that programmes are comprehensive and that gaps, overlaps and inconsistencies across services are minimized.

Above all, *government leadership*, including the establishment of a central body, is crucial to address the multi-determinants of health through formulating supportive public policies and co-ordinating actions across the government, non-government and private sectors to provide the favourable environment where families and children flourish. The development and implementation of these policies should also be evidence-based.

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Focus group discussion guide

- 1 What are your expectations in relation to the optimal development of preschool children in Hong Kong?
你對香港學前兒童的理想發展有那些期望？
- 2 How well do you think Hong Kong preschool children are doing at present?
你認為目前香港學前兒童一般的情況如何？
 - 2.1 Physical
生理方面
 - 2.2 Cognitive
智能方面
 - 2.3 Social emotional
社交和情緒方面
- 3 How well do you think their families are doing?
你認為目前香港學前兒童家庭一般的情況如何？
 - 3.1 Parenting (knowledge, skills, style)
親子方面(知識，技巧，方式)
 - 3.2 Family relationship
家庭關係(家人間的關係)
 - 3.3 Parent mental health
父母精神健康
 - 3.4 Others
其他
- 4 What are the needs of Hong Kong preschool children?
香港學前兒童有那些需要？
- 5 What are the needs of their families?
香港學前兒童家庭有那些需要？
- 6 What services/provisions are needed to meet these needs?
甚麼(那些)服務能滿足這些需要？
- 7 To what extent can the current services/provisions meet these needs?
現有的服務有多大程度能滿足這些需要？
 - 7.1 Areas where the services/provisions can meet the needs
服務能滿足需要(足夠)的方面/範圍
 - 7.2 Areas of unmet needs
服務未能滿足需要(未足夠)的方面/範圍
 - 7.3 Services/provisions that are not useful
沒有用的服務

- 8 For the unmet needs, how can they be met?
以上那些服務未能滿足需要(未足夠)的方面/範圍，如何才可滿足需要？
- 9 Who should provide these services/provisions?
誰去提供以上的服務？
- 10 Any other comments
其他意見

Chinese version of the quotes

Chapter 3

Section 2.3.8

我其實唔係好擔心香港幼兒嘅醫療服務，點解呢？即基本上醫院啦，甚至 MCH 啦，嘅服務其實做得好好，但我發現最大嘅問題係個教育嘅度，甚至係個社會制度，因點解呢？我哋太注重學識，太注重成就，變咗個學生好少運動啦，一無咗運動，佢就好易衰老，即好多嘅病，即而家講緊有一半嘅病可以用 exercise 就可以減低個 risk。(Group 14: I7)

一個就係 nutrition 喇，我提供到好嘅 nutrition 梗係少 D 病喇...咁偏食就係一個問題，on the other hand 就係又要 look out for 即 obesity。(Group 15: C20)

初初開始嗰時有人提到 health indicators 啦，我就覺得呢個係好 essential，譬如話睇 development 方面，我大膽 D 講基本上無乜 condition...係有一 D 好 clear 嘅 health indicator for Hong Kong，唔好講 Hong Kong，就算呢頭附近都唔覺有，咁變咗好多時候 planning 或專業人士培訓時就做唔到 D 應對嘅工作，咁呢個其實好緊要...同埋 D data 實在無一 D system 令到我知道原來你嗰個已經係第 D 地方數過，個仔 D data 已經話咗三次俾我聽。(Group 14: K33)

Section 3.7

我覺得小朋友學嘢好快，...即自己環境許可呢，可以俾多 D 嘢佢學，但佢即可以發揮得好 D，咁睇到佢有 D 咩係好呢，就加強佢呢 D 訓練。(Group 9: D1)

咁我發覺可能近呢一兩年嘅家長多咗好鍾意話將 D 小朋友出去學乜野學乜野學乜野。咁如果你講到話有 D 比較極端嘅例子都有 D 家長係講緊話可能一至五都有嘢俾佢學嘅，成個暑假都會 full 咗嘅。(Group 2: E13)

譬如歲幾已經問我哋會唔會教佢英文，會唔會同佢講英文。即有 D 咁嘅家長都有囉！(Group 3: B25)

D 家長全部都諗埋晒，佢應該多元智能發展，所以要學音樂，跳舞啦，跟住又學英文啦，仲有其他新嘅玩意，又帶佢去學，我覺得 D 細路仔其實都幾辛苦。(Group 7: A29)

我唔知啱唔啱，或者係學前嘅時候呢亦都去幫助佢哋去認識多 D 其他嘅語文。(Group 6: G16)

係呀，即個教育呢，好想可以學多D，即細細個呢就學英文。(Group 10: A100)

Section 4

譬如啦吓點樣同人哋分享呀、或者…點樣同人哋去做一個協商呀…即係佢哋有時其實係比較困難，呢D對於佢哋嚟講，佢哋覺得呢 D 好多嘢都係自己嘅，咁就er…同佢哋解釋但佢哋都唔會好明白囉，咁點解呢D嘢我要同你share 呢! 咁因為屋企全部嘢都係我嘅。咁我覺得呢一代的小朋友都會幾重呢方面嘅問題囉。(Group 1: F1)

佢地去解難嘅問題呢更加處理唔到，因為佢會覺得我一唔開心就有人嚟同我解決，總言之我就係唔開心，即我會類似就好似頭先咁發脾氣啦，…佢(家長)唔駛你諗點樣處理，佢就發咗出嚟，總之你就幫我解決佢囉，你順應我囉，如果唔係我就繼續發脾氣架啦。(Group 2: K15)

Section 5

我哋幼兒園，唔同區呀，或者唔咩階層都有，其實都會出現相類似的情況呀! 就係唔識得尊重人呀! (Group 1: D45)

我覺得社會上就缺乏左一個愛人愛己嘅精神。(Group 2: O83)

所以一D正確嘅價值觀、道德觀可以從學校學習。(Group 4: E41)

我希望栽培到一個真正的一個人，做返一個人生活應有的尊嚴同正確的價值觀。(Group 7: B169)

Section 6.3

咁特殊兒童呢，通常呢，佢哋個D，醒目嘅媽咪可能就好早留意到。留意到但係佢唔會，唔識得去diagnose佢係咪特殊，有D特殊嘅困難。咁呀，可能直到啦返到即係佢幼稚園啦! 當佢係個社交…咁一般家長，就會話曳啦、蠢啦、懶呀。其實，好多甚至幼稚園嘅老師啦都有個個能力去評估。除非，去到轉介去一D…兒童工作者個度。佢哋去做完評估先至可以知道咁嘅樣。但係呢一個過程呢，其實呢可能呢已經拖慢咗，幫助個小朋友囉。(Group 6: E38)

即report出咗嚟，話我個小朋友IQ好高，但無其他服務嗰，我周圍去打探，再去打電話，周圍問，乜野都無。(Group 9: C107)

Section 8.4

真係單親家庭嗰D嘅小朋友呢，佢哋做嘢係冇乜中心嘍，我哋嗰度好多都係咁。都發覺佢哋做嘢啦..我哋教嘢佢哋係識嘍。但係真係叫佢哋去做一D嘢呢係幾「呢hair」嘍...佢屋企可能係冇時間去管教呀！同埋嗰個愛呢，真係俾唔到佢。
(Group 1: E17)

或者就係好ignorant嗰班，咁即話有D新D嘅，落到來香港未必適應到環境嘅時候呢，咁佢哋更加會覺得好無奈，我唔識得湊，咁跟住呢，就會出現行為問題，大概係歲半至兩歲嘅呢就出現temper tantrum，就因為個細路仔唔識表達，佢又理解唔到個細路仔。(Group 12: I6)

不過我諗呢度呢可能同嗰個家庭嘅結構呢好多變化呢好有關係，舉個例即我地叫假單親，因為佢根本即媽媽成日都要上大陸嘅，即間歇性咁落來嘅。有D係年長嘅，即我諗係父母嗰個溝通呀，對小朋友嘅期望呀等等呢其實係有好大嘅差異呀。咁所以呢，我地睇到呢有時我地都覺得幾無奈呢就小朋友呢佢地年幼嗰個階段呢佢地需要幾多流轉，即一時又返吓大陸住吓幾個月，一時又返來，一時係阿婆度，一時又搬。即其實我諗呢，大家都知道咁樣咁唔stable嘅生活環境，對個小朋友嘅影響好大嘍。(Group 5: B13)

好多時係阿爸帶佢哋返來，但阿媽重係大陸嗰...我哋話俾佢聽，返去叫媽媽咁咁咁做，爸爸返去有無將呢 D 消息講俾佢聽就唔知嗰，咁我哋最多將個development 單張同佢講咗，之後叫佢返去將呢 D message 帶俾屋企人...所以就變咗教小朋友方面弱咗好多。(Group 12: J7)

Section 9.4

但係D lower class果D呢直程就係無野架，你‘質’飽佢就算啦咁。(Group 5: G16)

但係另外有一堆嗰D parent呢，係窮嘅，佢哋直程係連生活都manage唔到，佢根本都唔得閒理個細路哥，由得佢咁樣樣。(Group 15: I109)

或者文字上，佢哋係唔係真係睇得咁多呢！譬如有 D，或者有 D clinic 好多 lower social class 嘅就真係唔識嘍啦！有幾多媽媽返去有睇呢？即譬如我哋，咪有份 CPaP Development 嗰 D，咪一疊疊咁飛比佢係好多嘍。(Group 13: D41)

工人我諗唔會咁有心機同你慢慢去教嘅，總之你唔好煩住佢就最好，就算老人家都係嘍，佢地好著重個關係，總之佢肯叫佢嫲嫲爺爺，即以前佢唔肯比個仔做嗰 D 嘢佢都比佢做嘍。(Group 7: A40)

咁有D傭工係講D唔鹹唔淡嘅廣東話，加一D唔係好純正嘅英文，咁變咗家長即依家工作嘅家長又比較多，變咗真係少咗時間對住D小朋友囉，好多時甚至一D學習嘅活動都好依賴家庭傭工幫，我唔否定有D家庭傭工係好幫得手，但亦有一D家庭傭工嘅語言能力都唔係好高啦，無論係英文定中文。咁變咗有D小朋友佢係呢個所謂 **bilingual** 嘅階段裏面呢，其實佢就唔係 **bilingual**，…佢祇不過係聽到一D唔係好正嘅發音。而佢又因為缺乏左D比較緊湊D嘅…家長嘅關注呢，咁可能係發音上係有D問題，咁亦都影響到呢佢表達呢。(Group 2: M4)

Section 10.4

D小朋友D壓力都幾大，咁即好細個D父母就要求好高，要學好多嘢，識好多字，咁就嗰個 **training** 又唔得法，又猛咁塞D嘢，D小朋友有時未必到嗰個程度，…就會忮憎，引致個小朋友就有好多 **behaviour problem**。(Group 16: E10)

有D園係 **middle class**，嗰D家長嘅要求幾高。即甚至點解我哋先生朝頭早返來要全部講晒英文，即有D家長係咁嘍，即你要英文嘍。(Group 5: G16)

香港嘅細路仔係 **over protective**，即好多時四，五歲，叫佢譬如刷牙，咁媽咪幫佢除衫除褲，咁 **examine** 完，佢就可以棟咗嘍度，等阿媽幫佢著衫著褲。(Group 16: B38)

即扭計嗰陣時囉，即要好順佢意囉，即要忮佢呀咁。即佢都聽嘅，即你如果忮佢啱佢意思嘅都肯收聲呀嗰隻囉。(Group 8: B18)

有時我哋去睇一個家長佢將個小朋友…擺喺幼兒園啦。根本我地嗰個 **care** 嘅時間已經係好長嘍啦，朝八晚八。但係佢唔得嘍，即佢基本呢八點鐘都來接唔到佢。所以呢，呢個小朋友會由第二個人來接佢，返屋企照顧佢一輪，然後媽媽十點鐘先返來嘅。(Group 5: B6)

其實因為嗰D家長對學前教育，對小朋友嘅成長呀，生理呀，或者心理各方面嘅發展。其實係唔係好認識囉！所以呢，其實有時佢嘅期望係唔合理！(Group 3: A16)

Chapter 4

Section 18.1

即變咗零至三歲，你衛生署去 **take care**。但係呢，其實你學前應該係去到六歲嘍嘛。譬如，頭先我哋話三、四、五係冇人理嘍！但係…有一D嘢係三歲以後先發展嘍嘛。咁跟住你衛生署就唔理，咁由得嗰D家長自己都未必認識到自己細蚊仔嗰個發展有咩問題嘅。(Group 6: B40)

佢哋返來打完針，一歲半返來見多我哋一次，跟住就飛咗去啦，可能 2nd P.E.都唔返，好多時中間呢個 gap 就係 language delay 出問題嘅時候，好多時我哋都 detect 唔到，就因為家長覺得我都無返來，又無人話俾我聽呢個係有問題嘅嘢，即沒有一個好正途嘅 information 俾到佢哋，就返到來，小朋友已經三歲，仲好似鸚鵡咁，咩呀？點呀？即佢就喺度咁跟你講，咁就弊啦！（Group 12: F33）

Section 18.2

而家有好多幼稚園呀！即都好着重 D academic 多 D 囉。即要 D 小朋友寫字呀！即同埋，即先生嘅要求亦直接影響到嗰個家長嘅要求囉！咁所以，一到到三歲呢！一入學呢，嗰 D 家長就好緊張。功課呀！或者即係要參加 D 咩嘢，學 D 乜嘢嘢啦！其實，我就覺得…呢 D 牽涉咗整個香港嘅教育。係一個唔係咁好嘅發展囉，對 D 細路仔。（Group 13: C70）

而係依家太過注重 D 知識嘅嘢，即少 D D 倫理、家庭關係啦，即呢方面嘅嘢教導比較少，即注重知識囉。（Group 9: F68）

不過都係因為無錢，經濟唔好，所以都好少資源 focus 在 early childhood education。（Group 4: D45）

個 welfare and education and development 嗰方面好缺乏，咁如果你話教統局覺得零至三，三至六係唔關佢事呢，根本就無可能㗎，early education 唔係 education 㗎？！佢話唔係 education，咁我唔知係乜呢？係好大荒謬。（Group 14: K35）

同埋依家所有研究都講學前教育越嚟越重要，唔好話六歲，三歲之前已經話決定佢好多，但係我哋依家都唔支助學前教育㗎，其實應該搵最好 D 師資，大學畢業 D 去教。（Group 7: A84）

大家都講 D preschool educators 係咪需要 educate 吓？咁我哋需唔需要 make suggestions 俾 government 去做呢樣嘢，即依家可能點解，因為係 proportional to 嗰個 salary㗎嘛，好多時香港 D 人都覺得 preschool D 人係唔係咁重要，而且 run 嗰 D preschool D 人都要睇個 cost，變咗咁嘅人工就搵到 D 咩嘢人，我諗都係 proportional to salary。（Group 14: G55）

同埋我覺得依家香港教育呢，個學生同老師個比例都係相差太遠。（Group 9: C25）

Section 19.1

我都覺得呢啲幼稚園呢個家長教育呢，社會呢係要負責嘅，因為佢地真係年輕呀嘛，好多都係廿「靈」歲呀三十歲呀咁樣就已經做父母，咁亦都有好多係專業

人士，咁但亦都未必呢代表呢佢係一個對兒童發展係有認識，或者係對兒童教育呢係有認識嘅，因為我覺得有需要俾佢地知。(Group 2: L25)

一，教育嘅起步點由懷孕階段要開始，二，responsible parenthood。(Group 4: C43)

話佢哋未生嗰陣時呢，好 receptive 咁，好想對呢個 BB 有 expectation，希望盡早 prepare，咁嗰陣時呢個 BB 又未出現，佢有嘞心機去攞呢 D，佢個 BB 出咗世，成日賴屎賴尿，根本都無時間去再上堂喇，咁所以我就話，係佢生之前嗰陣時盡量灌輸多 D 呢 D 嘢俾佢。(Group 15: J41)

即肯嚟我哋D workshop，肯嚟我哋 support group 嗰 D 呢。其實就唔係咁需要幫果 D client，唔肯嚟嗰 D 呢先最需要囉，先最慘囉！最慘就係有辦法幫到呢 D 囉。(Group 13: A112)

我哋學校都會自己攞 D 家長講座呀！其實，D 家長 D 出席率都唔係咁高呀！即係佢哋要返工呀，要乜野呀！即佢哋D 時間又長咗呀！佢哋工作又艱辛呀！即係各方面囉！（Group 3: B34）

暫時就未，即無報過，唔係咁需要囉就，即我小朋友都慢慢大個啦。即譬如第一任媽媽嗰 D 我就唔知啦，即佢地 BB 細個，即未湊過 B B 嗰 D 可能會囉，但係我無參加過呢 D。(Group 8: B43)

無呀，我先生有個朋友，佢就聽過呢 D 講座，佢話無咩作用呀佢話，佢話聽嚟都無咩用。(Group 10: A68)

Section 19.2

另外我都覺個 coordination 都好重要，個個都做自己嗰套，個個有自己 programme，…但個問題係點樣 co-ordinate 署與署之間，局與局之間嘅，大家資源嘅傳遞，咁嗰 D 資源就唔會咗…我唔係話大家共用一本書，但如果一 D 基本嘢可以有協調，有共同點嘅，咁就有個方針及範圍，咁大家做嘅時候就唔會咁費資源，個 co-ordination 係好重要。(Group 4: D55)

我哋係冇社工嘅，我哋日頭明知嘅，園長明知佢哋多方面嘅壓力，家庭接受嘅壓力呢、情緒上嘅壓力。但好多時礙於我哋無專業嘅知識呀！我哋好難去幫到佢。(Group 1: L56)

我哋有夢嚟，係一校一社工，因我見到 D 園長、校長做好多 counselling，…但幼兒園 D 家長就一個星期都會湊吓小朋友返學，同主任呀、老師呀 D 關係好 D，

以致屋企 D 家庭問題就會帶返學，我都聽過有 D 家長希望自殺、離婚呀，爸爸有工傷或者 D 乜野病，佢第一個求助就係學校嘅主任，可能建立咗個關係，變咗一來老師或主任未必有呢方面嘅 skill，好吃力，所以我會有呢個夢。(Group 4: D47)

其實係見到國內有 D 嘅學校呢係每日會有一個護士，係當佢入學校嘅時候幫小朋友檢查下身體，…但香港呢方面真係比較少，但如果靠我哋老師，我哋可能都有呢方面嘅專業知識，…可唔可以係身體健康方面俾多 D 嘅支援我哋幼稚園，咁我哋幼稚園已經係叫做係困難又困難當中，咁如果話衛生署好，政府俾多 D 支援，都可以減輕我哋老師嘅呢方面嘅或者擔心呀。(Group 2: C65)

如果能夠做到一校一醫生嘅話就最理想囉！…即係我哋都有同一 D 醫生接觸過，可唔可以提供一 D 資源比我哋呀！即係我哋有問題可唔可以直接同佢哋聯絡呀！咁佢可以俾 D 專業知識我哋呀，幫我哋解決問題呀咁。(Group 3: D52)

我覺得有個 XXX 嘅 community service 幾好，落 D 幼稚園嘅 assess D 細路仔，即其實佢撈到好多三歲唔返 MCH 嗰「渣」，咁同理 D 家長個 response 都幾好。(Group 12: D72)

我最近收到一個 email 有關一校一醫生，但依家就 stick to 答 D 問題關於 SARS 呀，咁佢係 SARS 都會停㗎，其實值得 continue 呢 D programme…咁我諗 one doctor, one school 係幾好。(Group 14: G67)

D 兒童去 screening 喇，screening 完我哋都唔知咩事發生咩事，拎番嚟佢又唔會將報告拎番嚟，咁嗰個報告即點，你 centre oriented，即唔係嗰個 patient nor the doctor oriented。(Group 15: D101)

咁我哋健康院講明唔睇大病，咁有時會同私家有個 interface 嘅嘍，…個仔病，以前好彩的話就搵番晒出嚟，如果唔好彩，就會 miss 咗好多。(Group 16: H86)

我諗實際上呢個 service 就係兩個極端嘅。咁一係就 MCH，佢哋可能，佢個醫生呢係普通科醫生，佢哋唔會好好 sort out 個問題，一係第二個極端呢，醫院嘅 specialist 呀或者 special consultation，咁呢個你知個門口都好高，又難約呀…可能淨係 book 時間都要親自去，…所以我諗中間嗰 D 中間 level 嘅 service 就可以 more immediately accessible 同埋唔需要咩咁多 formality 就得。(Group 15: J29)

其實，我又覺得可以地區性囉。譬如，你果到嗰個區域裏面，一 D 嘅幼兒中心呀！幼稚園呀！即大家同我哋母嬰健康院，大家有個聯繫。(Group 13: F73)

間間學校都做！衛生署又做！自願團體都做！但係呢，可能擺到嘅野都唔知一唔一致！如果有個 base 呢！係社區嘅 base 呢！係大家自願團體又好、以 creche 嚟做一個單位又好、咁同大家一齊合作。咁其實，我諗係資源上就用得更好。(Group 3: A71)

其實就係話係需要好似有個家庭醫生咁。...佢真係佢呢個細路仔一路跟，甚至跟到起碼一路去到小學，即中學之前呀。佢係好清楚知道呢個兒童嘅發展㗎。...但起碼佢係一個醫生啦，佢係可以係一個 record，即一路睇到個細路仔發展成點啦。(Group 6: E42)

Section 19.3

我覺得最大個 point，政府一定要有兩樣嘢，決心同資源，如果政府無呢兩樣嘢，點講都無用。(Group 14: A56)

先由政府果到去諗 D 功夫去做呢，係唔係呀？可唔可以去立法，有 D 機構規定個僱員有細路哥嗰 D，會譬如，比一 D 假期嗰 D 家長。佢係可以請呢 D 嘅去嘅出席一 D 嘅家長教育。(Group 3: F54)

同埋講番幼稚園嗰嘢，我唔知教統局做唔做到 D 嘢囉？其實我知教統局有 D 好 standard 嘅標準俾佢哋㗎...但係間間幼稚園為咗搵錢，為咗搏出名，咁自己就調高咗個 level，呢樣嘢如果可以 control 得好 D，我諗對一個 0 至 5 歲嘅小朋友，佢哋都可以受益。(Group 16: B68)

即 private child minder 可以係一個 market，亦都可以係一個 child rearing 嘅保證，係嗰嘢無論係個 training，無論係 registration，可以做得好 D 嘅話，即係嗰嘢係保障 carer 嗰個 quality 嘅一個基制。(Group 5: F58)

Chapter 5

Section 8

咁我哋有無 D pilot study，如果有 rehabilitation，搵 D volunteer 去做嘅，咁呢 D programme 我哋點去 evaluate 呀？...或者做 D Triple P evaluation 嘅時候，究竟又係點呢？(Group 14: H28)

List of training courses for Qualified Kindergarten Teachers (QKTs) and Child Care Workers recognized by the Education Department (ED) and Social Welfare Department (SWD):

獲教育署及社會福利署認可的合格幼稚園教師及幼兒工作人員訓練課程一覽表:

Name of Institution/Courses 授課學院/課程名稱	Effective date of recognition by SWD 社會福利署認可日期	Effective date of recognition by ED 教育署認可日期
<p>Hong Kong Baptist University, School of Continuing Education 香港浸會大學持續教育學院</p> <ul style="list-style-type: none"> ◆ Certificate in Early Childhood Education Course 幼兒教育證書課程 ◆ One-year Pre-service Basic Early Childhood Education Course for 2001-02 2001/2002 一年全日制職前幼兒教師培訓課程 	<p>Since 4.6.1997 自 4.6.1997 開始</p> <p>Since operation 自開辦始</p>	<p>Since 4.6.1997 自 4.6.1997 開始</p> <p>Since operation 自開辦始</p>
<p>Hong Kong Polytechnic University 香港理工大學</p> <ul style="list-style-type: none"> ◆ Certificate Course in Pre-primary Education (Distance Learning) 學前教育證書課程(遙距課程) ◆ Certificate Course in Pre-primary Education for 2000/2001 (1-year pre-service Full-time) 2000/2001 學前教育證書課程(一年全日制職前課程) ◆ Bachelor of Arts (Honours) in Pre-primary Education (Note 1) 學前教育(榮譽)文學士學位課程(註一) 	<p>Since 24.7.1989 自 24.7.1989 開始</p> <p>Since operation 自開辦始</p> <p>Since 18.2.2002 自 18.2.2002 開始</p>	<p>Since 8.10.1997 自 8.10.1997 開始</p> <p>Since operation 自開辦始</p> <p>Since 18.2.2002 自 18.2.2002 開始</p>

Name of Institution/Courses 授課學院/課程名稱	Effective date of recognition by SWD 社會福利署認可日期	Effective date of recognition by ED 教育署認可日期
<p><i>The Hong Kong Institute of Vocational Education</i> (<i>Lee Wai Lee</i>) 香港專業教育學院李惠利分校</p> <ul style="list-style-type: none"> ◆ Certificate in Child Care (1-year full-time pre-service mode) 幼兒工作證書(一年全日職前訓練制) ◆ Certificate in Child Care (2-year part-time day release in-service mode) 幼兒工作證書(兩年日間部份時間給假調訓在職訓練制) ◆ Vocational Certificate in Basic Child Care Work (1-year part-time day release in-service mode) The course was named as Certificate in Basic Child Care Work (1-year part-time day release in-service mode) prior to 1999-2000. 基本幼兒工作職業技術證書(一年日間部份時間給假調訓在職訓練制) 此課程於 1999/2000 前稱為基本幼兒工作證書 ◆ Diploma in Child Care and Education (Pre-service 2-year Full-time) 幼兒教育文憑(兩年全日職前訓練制) ◆ Higher Diploma in Child Care and Education (Pre-service 3-year Full-time) (Note 2) 幼兒教育高級文憑(三年全日職前訓練制) (註二) 	<p>Since 5.5.1988 自 5.5.1988 開始</p> <p>Since 5.5.1988 自 5.5.1988 開始</p> <p>Since 3.3.1995 自 3.3.1995 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p>	<p>Since 19.11.1997 自 19.11.1997 開始</p> <p>Since 19.11.1997 自 19.11.1997 開始</p> <p>Since 19.11.1997 自 19.11.1997 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p>

List of training courses that has met the requirements of the framework of the Certificate in Early Childhood Education [an equivalent training of the Certificate in Kindergarten Education] and recognized by the Education Department (ED) and Social Welfare Department (SWD):

符合幼兒教育證書課程的課程架構要求(亦即幼稚園教育證書課程的同等訓練)並獲教育署及社會福利署認可的幼兒教育證書課程一覽表:

Name of Institution/Courses 授課學院/課程名稱	Effective date of recognition by SWD 社會福利署認可日期	Effective date of recognition by ED 教育署認可日期
<p>Hong Kong Baptist University, School of Continuing Education 香港浸會大學持續教育學院</p> <ul style="list-style-type: none"> ◆ Advanced Diploma in Early Childhood Education Course 幼兒教育高級文憑 	<p>Since 30.6.2001 自 30.6.2001 開始</p>	<p>Since 30.6.2001 自 30.6.2001 開始</p>
<p>Hong Kong Institute of Education 香港教育學院</p> <ul style="list-style-type: none"> ◆ Certificate in Kindergarten Education (Chinese) Programme (2-year Day Release or Evening Mixed Mode) 幼稚園教育證書(中文)課程(二年日間/夜間混合制) ◆ Certificate in Kindergarten Education (Chinese) Programme (3-year Part-time Evening) 幼稚園教育證書(中文)課程(三年夜間部份時間制) ◆ Certificate in Early Childhood Education (Chinese) Programme (3-year Full-time) 幼兒教育證書(中文)課程(三年全日制) 	<p>Since operation 自開辦始</p> <p>Since operation 自開辦始</p> <p>Since operation 自開辦始</p>	<p>Since operation 自開辦始</p> <p>Since operation 自開辦始</p> <p>Since operation 自開辦始</p>
<p>Hong Kong Polytechnic University 香港理工大學</p> <ul style="list-style-type: none"> ◆ Higher Diploma in Pre-primary Education (Note 3) 學前教育高級文憑(註三) ◆ Bachelor of Arts (Honours) in Pre-primary Education 學前教育(榮譽)文學士學位課程 	<p>Since 31.5.2001 自 31.5.2001 開始</p> <p>Since 18.2.2202 自 18.2.2002 開始</p>	<p>Since 31.5.2001 自 31.5.2001 開始</p> <p>Since 18.2.2002 自 18.2.2002 開始</p>

Name of Institution/Courses 授課學院/課程名稱	Effective date of recognition by SWD 社會福利署認可日期	Effective date of recognition by ED 教育署認可日期
<p><i>The Hong Kong Institute of Vocational Education (Lee Wai Lee)</i> 香港專業教育學院李惠利分校</p> <ul style="list-style-type: none"> ◆ Higher Diploma in Child Care and Education (Pre-service) (3-year full-time) 幼兒教育高級文憑 (三年全日職前訓練制) ◆ Higher Diploma in Child Care and Education (Part-time module accumulation course) 幼兒教育高級文憑 (部份時間單元儲修制) ◆ Two-year In-service Certificate in Early Childhood Education Course (Higher Diploma in Child Care and Education) 二年制在職幼兒教育證書課程 (幼兒教育高級文憑) 	<p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since operation 自開辦始</p>	<p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since 27.11.2001 自 27.11.2001 開始</p> <p>Since operation 自開辦始</p>

Note 1

Students who have successfully completed Stage 1 and 2 of the Bachelor of Arts (Honours) in Pre-primary Education may apply for individual recognition of Child Care Worker or Qualified Kindergarten Teacher equivalent qualifications.

註一

已成功完成學前教育（榮譽）文學士學位課程第一及第二階段課程之學員，可申請獨立認可其幼兒工作人員／合格幼稚園教師等同資歷。

Note 2

Students who have successfully completed Year One of Higher Diploma in Child Care & Education may apply for individual assessment of Child Care Worker/Qualified Kindergarten Teacher equivalent qualifications.

註二

已成功完成幼兒教育高級文憑(三年全日職前訓練制)第一年課程之學員，可申請獨立評估其幼兒工作人員/合格幼稚園教師等同資歷。

Note 3

Graduates of the Higher Diploma in Pre-primary Education who graduated before 31.5.2001 could apply for qualification recognition and they will be assessed on individual basis.

註三

於 31.5.2001 前修畢學前教育高級文憑之學員，可申請學歷認可，社會福利署/教育署將根據個別情況審批其學歷。

Health Indicators

The purpose of this document is to provide summary information about child health indicators in various countries. This document is based on several national child health reports in western countries. The reports cited include:

- Australia - Australia's children, their health and wellbeing 2002 (Australian Institute of Health and Welfare, 2002)
- Canada - The health of Canada's children: a CICH profile (Canadian Institute of Child Health, 2001) and Profile workshop final report
- European Union – European Union community health monitoring programme: Child health indicators of life and development (CHILD) – Report to the European Commission (Rigby & Köhler, 2002)
- U.K. - Child health statistics (Office for National Statistics, 2000a)
- U.S. – America's children: key national indicators of well-being 2003 (Federal Interagency Forum on Child and Family Statistics, 2003) and Trends in the well-being of America's children & youth 2001 (Department of Health and Human Services, 2001)

In addition, the “Best Start” programme in Victoria, Australia has completed a project on health indicators for the “Best Start” programme and the project report is also referred to in this document. The “Best Start” indicators project (Department of Human Services, 2002)

Other documents referred to in this document are:

- U.S. – Healthy people 2010: Understanding and improving health (Department of Health and Human Services, 2003)
- U.K. - The mental health of children and adolescents (Office for National Statistics, 2000b)

Definitions of health indicator

- A variable, susceptible to direct measurement, that reflects the state of health of persons in a community (Last, 2001, p.83)
- A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time) (WHO, 1998, p.9)

Criteria for selecting/developing health indicators

In all the reports except the UK report, there is a section on the criteria for the selection or development of health indicators. Based on the reports, the key/common criteria for selecting/developing indicators mentioned include:

- Well recognized as indicators of child well-being, objectively based on substantial research connecting them to child well-being
- Easily understood by the public
- Being measured regularly

According to the Healthy People 2010 (Department of Health and Human Services, 2003), health indicators are chosen based on “their ability to motivate action, the availability of data to measure their progress and their relevance as broad public health issues” (p. 24). The European Union also states that the topic must be amenable to effective action.

Development of the indicators

In some of the reports, the process of selecting/developing the indicators was described. Usually, the indicators are selected/developed by a group of experts with expertise in child health, usually with input or endorsement from the policy makers.

Theoretical models behind the selection/development of the indicators

The theoretical model(s) behind the selection/development of the indicators was described in three of the documents. The three documents are similar in their emphasis on multiple determinants of health (ecological framework). In addition, both the Canadian and Australian frameworks include a developmental perspective and the definition of health as encompassing physical, cognitive and social emotional aspects.

Indicators by categories

In most cases, the categories include the child's personal health status, environmental factors (especially the family), and service delivery.

Indicators and data sources

In the countries reviewed, there are national level mechanisms for regular data collection in relation to the indicators, supplying updated information. This kind of infrastructure is important for the regular updating of the indicators. Possibility of regular measurement is a criterion for indicator selection, as mentioned above.

Summary of common indicators relevant to preschool children

Below is a summary of indicators which are relevant to preschool children which are adopted in at least two countries (excluding Best Start as it is at state level). The availability of data in Hong Kong is also listed for reference. In the Hong Kong situation, there is territory-wide information available for most of the indicators in the physical domain and some indicators in the family domain. However, data for the cognitive and social/behavioural domains and parenting are more limited.

Summary of common indicators

Domain	Indicator	Australia	Canada	EU	UK	US	HK source
Physical	Birth weight	✓	✓	✓	✓	✓	DH statistics
	Infant mortality	✓	✓	✓	✓	✓	DH statistics
	Child mortality	✓		✓	✓	✓	DH statistics
	Immunization	✓		✓	✓	✓	DH statistics
	Breastfeeding	✓	✓	✓	✓		FHS survey
	Injury mortality	✓	✓	✓	✓		DH statistics
	Injury hospitalization		✓	✓			HA statistics
	Incidence of vaccine preventable disease	✓	✓	✓			DH statistics
Cognitive	Children being read to		✓			✓	One small scale survey
	Pre-school enrolment			✓		✓	Census and Statistics Department
Social/behavioural	Social/behaviour/mental problems	✓ ¹	✓ ²	✓ ³	✓		Individual surveys on behaviour problems
Family	Income/education/employment	✓	✓	✓	✓	✓	Census and Statistics Department
	Family structure	✓	✓	✓	✓	✓	Census and Statistics Department
	Parenting/family functioning	✓ ⁴	✓ ⁵	✓ ⁶	✓		Individual surveys

References:

Australian Institute of Health and Welfare (2002). *Australia's children: their health and wellbeing 2002*. Canberra: Australian Institute of health and Welfare.

Canadian Institute of Child Health (2001). *The health of Canada's children: a CICH profile* (3rd ed.). Ottawa: Canadian Institute of Child Health.

¹ The Child Behaviour Checklist was used in the National Survey of Mental Health and Wellbeing to examine emotional and behavioural problems.

² There are four measures of behaviour from the National Longitudinal Survey of Children and Youth, covering emotional problem-anxiety, hyperactivity, physical aggression and prosocial behaviour.

³ Annual incidence of attempted suicide, defined by inpatient hospital stays with a discharge diagnosis of attempted suicide, per 100,000 population, in age-groups 10-14 and 15-17.

⁴ Measure of family cohesion by asking parents of children aged 4 to 17 years about the family's ability to get on with one another.

⁵ Measures include parenting style (positive interaction and family interaction) and time spent with children, from National Longitudinal Survey of Children and Youth.

⁶ Measure of parental support for children, defined by percentage of children reporting that they find it easy or very easy to talk with their parents when something is bothering them. Data available for ages 11, 13 and 15 only.

- Department of Health and Human Services (2001). *Trends in the well-being of America's children & youth 2001*. Retrieved September 23, 2003 from: <http://aspe.hhs.gov/hsp/01trends/intro.htm>
- Department of Health and Human Services (2003). *Healthy people 2010: Understanding and improving health*. Department of Health and Human Services.
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- WHO (1998). *Health promotion glossary*. Switzerland: World Health Organization.