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ABSTRACT

Because in the normal course of events most children become briefly ill, families are forced to deal with problems of arranging alternative child care. This article develops a model of the factors influencing family day care workers' acceptance of acutely ill children into care. The article begins with a summary of the research on which the model is based, which found that: (1) the overall training of care providers impacts their level of concern for dealing with sick children; (2) those providers who are very concerned about dealing with sick children have problems with difficult children in general, and with planning and curriculum; and (3) the stress level of very concerned providers is related to their perception of the complexities of caring for well and sick children at the same time. The article then describes the model's six components. They are the provider's: (1) education and training, with more education leading to more competence; (2) recognition of illness, which is enhanced through experience and education; (3) susceptibility to pressure, based on a complex mix of personal, interpersonal, and economic factors; (4) home and family, with the caregiver's physical circumstances influencing the ability to accommodate an ill child; (5) professional responsibility, with professional associations enhancing caregivers' decision-making ability; and (6) societal and cultural context, which influences procedures and accommodations made for the care of sick children. Contains 14 references. (EV)

SPECIAL NEEDS CHILDREN: SICK CHILDREN - A CHALLENGE FOR CHILD CARE

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Introduction

The provision of services for special needs children is a growing concern in many Western nations. Many challenges are confronted by the providers of special needs services for young children and their families. One group requiring care is the chronically disabled which include the physically, emotionally and mentally challenged. A second group who frequently require specialized services is the chronically ill. The chronically ill include those with specific conditions such as diabetes and asthma. Many of these children require medications and/or the carrying out of manual activities or procedures. However a third group contains nearly all families who have children in child care. Since in the normal course of events, most children at one time or another become ill forcing their families to deal with the issues of lost work, seeking alternative arrangements, or requesting provision of service from child care providers.

When a child becomes ill, employed parents face the dilemma of providing care for the child and possibly losing work to provide care. The United States National Child Care Survey (1990) indicated that 35 % of mothers employed outside the home reported that one of their children was ill in the past month. Over half of those mothers stayed home to provide care. Of those who did go to work when their children were sick, 21 % reported that their partners stayed home, over a third left the child with relatives, almost a quarter used their regular care, 6 % used self-care, 4 % took the child with them to work and 10 % used other arrangements. It is sometimes reported that regulated family day care providers are more likely than centre-based programs to accept sick children. About 25 % will permit parents to leave

children with severe coughs, 20 % accept children who appear feverish, and 10 % permit children with rashes.

In France, Collet et al. (1994) studied the risk of infectious diseases in children attending different types of day-care settings and the incidence of recurrent infections in children attending family day care, small (10-20 children) day-care centers (DCCs), and large (> or = 40 children) DCCs. Compared to those in family day-care, children attending small DCCs presented a higher risk for infectious episodes. The risk for children attending large DCCs was intermediate between the family day care and the small DCCs. This study reports the incidence rate of disease in various forms of child care without investigating the criteria or the process of exclusion for ill children.

The purpose of this paper is to develop a model of the factors influencing family day care providers' acceptance of acutely ill children into care. This paper extends the work of Thompson (1993) who described the process that employed mothers used to make decisions about sick children. Thompson based her analysis on interviews with employed mothers concerning the difficulties they experienced in making decisions about the care of sick children. The present model is partially derived from a research base of studies conducted with E. Polyzoi and summarized below. The first study (Polyzoi & Kerr, 1993) identified concerns of trained and untrained family care day providers. The second one (Kerr & Polyzoi, 1995) ascertained the importance of dealing with sick children for family day care providers and the constellations of other concerns that are relevant to these providers.

Research base

The Family Day Care Association of one Canadian Province distributed a questionnaire to its membership of 385 licensed family day care providers. These members come urban and rural communities and provide neighbourhood service to primarily low income, subsidized families. Two hundred and thirty (60%) providers returned the survey. This survey requested information concerning the role of licensing, training, years in the field, subsidization, professionalism, and daily functioning in the family day care home.

Respondents were asked to rate items of concern for them as family day care providers. The items were rated 1 (not important) to 5 (very important). Further analyses of this information revealed two principal factors. The major factor was "concern for sick children". The second factor was "the mechanics of operating a business" which included items about delays of payment from the government and delays in the application process. The first factor contributed 22.9 % of the variance and the second contributed 9.6 %. The factor scores for the two primary factors were computed for each of the family day care providers. An ANOVA was performed on these factor scores

based on the level of formal training received by the provider. Figure 1 shows a the differences on Factor 1, concern for sick children, based on the training level of the provider. Those individuals with little or no training were more concerned about their capacity to care for sick children than were those who had received at least community college training.

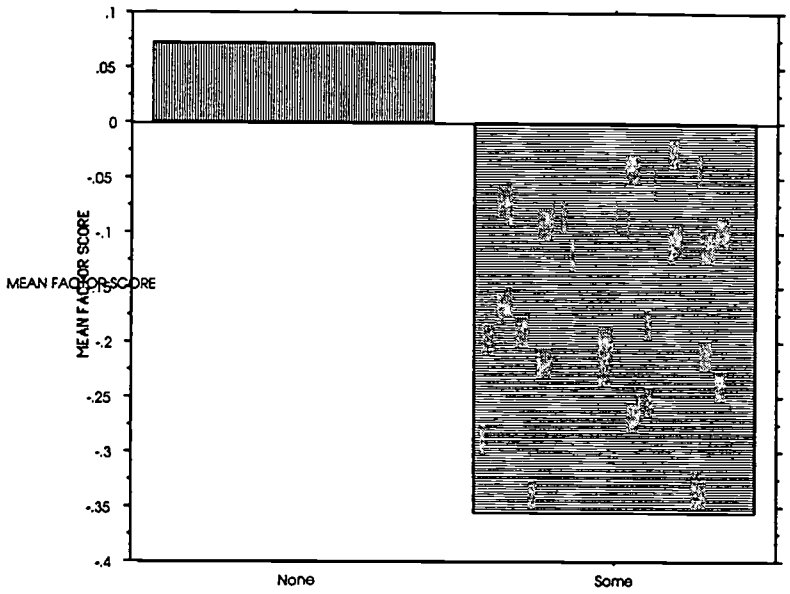

Figure 1. Mean score on concern for sick children for providers with no or some formal training.

The providers were classified on their level of concern for sick children based on their factor score. A series of comparisons were made among the providers categorized as high (N = 47), medium (N = 103), and low (N = 46). Table 1 shows the differences between the high, medium and low concerned. From this it can be seen that specific factors may influence the family day care providers' willingness to include ill children within their care.

Table 1. Means and standard deviations of issues for providers based on factor score.

	LEVEL OF CONCERN OVER FAMILIES WITH ILL CHILDREN					
	High		Medium		Low	
Concerns and issues	M	SD	M	SD	M	SD
1. Families who bring sick children to care[a,b,c]	4.79	.41	3.50	1.01	1.29	.6***
2. Delays in receiving payment for services	3.38	1.63	2.80	1.56	2.80	1.65
3. The amount of money I earn for the work[a]	3.43	1.25	3.07	1.34	2.84	1.40*
4. The long hours of work	3.34	1.19	3.06	1.27	2.84	1.45
5. The wear and tear on my home	3.04	1.44	3.00	1.16	2.38	1.35
6. Stress if the job[a]	3.38	1.19	2.89	1.11	2.76	1.38*
7. Delays in subsidy approval	2.81	1.67	2.98	1.46	2.80	1.60
8. Feeling tired, overworked, under-appreciated	2.94	1.37	2.85	1.23	2.84	1.51
9. Isolation in working without adults	2.66	1.34	2.67	1.32	2.84	1.52
10. Dealing with difficult behavior[a]	2.88	1.22	2.53	1.06	2.24	1.25**
11. Talking to parents about problems	2.64	1.34	2.43	1.17	2.27	1.18
12. The clutter in my home	2.49	1.38	2.59	1.27	2.33	1.26
13. Finding clients	2.11	1.41	2.60	1.45	2.38	1.35
14. Keeping records and doing taxes	2.57	1.22	2.61	1.42	2.42	1.42
15. Budgeting my money[a,c]	2.81	1.35	2.40	1.40	1.84	1.15***
16. Coming up with ideas for games etc.[b]	1.77	1.11	2.11	1.19	2.22	1.22*
17. Talking with clients about contracts	2.27	1.15	2.20	1.21	1.96	1.22
18. Understanding the subsidy system	1.96	1.25	2.24	1.23	1.84	1.24
19. Understanding children's behavior[a]	2.40	1.74	1.99	.99	1.69	.79*
20. Doing things required for licensing	2.01	1.20	2.10	1.17	1.96	1.24
21. Dealing with government staff	1.86	1.12	1.70	.99	1.91	1.49

Note.
1. The items are ordered from the most to the least item of concern for the total group. The item of greatest concern was over families who bring sick children.
2. n=47 high concern group, n=104 medium group, n=45 low group
3. [a]=difference between high and low group; [b]=difference between high and medium group; [c]=difference between low and medium
4. * p<.05, ** p<.01, *** p<.001

The high group had worked in day care an average of 7.70 years, the medium group an average of 6.03 years, and the low group an average of 9.14 years. However, the major difference among these family day care providers was in the number of years they had worked prior to being licensed because the low group had more years of prior experience than the medium group.

Those providers who were the most concerned about sick children also differed from other providers in the identification of other important behaviors as assessed by the questionnaire. Such differences included being more concerned about understanding children, dealing with difficult child-

ren and developing curriculum. As well, they rated stress and financial worries highly. Therefore, these providers demonstrated a picture of stress characterized by dismay over the difficulties of dealing with sick and well children, and over budgetary issues.

In summary, the research of E. Polyzoi and myself on family day care providers implies that:

1. The overall training of family day care providers may impact on their level of concern for sick children and their families. Those individuals with little formal education in child care are more concerned than those with approximately two years of child care education about their capability to handle ill children.

2. Those providers who are very concerned about dealing with sick children and their families indicate problems in understanding children in general, in handling sick and well children who are difficult, and in planning activities and curriculum.

3. The stress level of those providers who are very concerned about dealing with sick children and their families may be influenced by the dilemmas imposed by concern over the complexities of providing care for well and ill children, the possible loss of income if they do not accept sick children, and the probable contagion effect of having sick children around other children, themselves and/or their own families.

The challenge of providing for sick children and their families is based not only on the process of parental decision-making as shown by Thompson (1993), but also on the decision-making of the providers. From a societal and family perspective, the early childhood provider's willingness to accept ill children into care impacts on the financial and emotional well-being of the total family. Therefore, it is important to consider the issues that may influence such willingness. The proposed model includes many important forces on the provider during the decision making about incorporating a sick child within a family day care home is shown in Figure 2.

Provider's decisions about caring for sick children

The model is composed of six forces in the lives of providers. These six forces are providers' education and training, their competence in illness recognition, the provider's vulnerability to pressure, the home and environment, the commitment to professional responsibility and the social-cultural context that enhances or facilitates the general care of young children.

INFLUENCING FACTORS

Provider's Education and Training
* Ability to understand children * Competence with sick children * Capability to establish curriculum and activities * Proficiency with difficult children
Provider's Recognition of Illness
* Alertness to presence of child's symptoms * Awareness of characteristics of illness * Knowledge of infection diseases and implications * Availability of health and child care consultants
Provider's Susceptibility to Pressure
* Lack of alternate care arrangements for family * Budgetary and financial impact of excluding ill children * Liability for poor outcomes, e.g. medication side-effects * Personal and professional relationship with parent
Provider's Home and Family
* Areas to provide isolation for ill child * Vulnerability of provider's family to illness * Vulnerability of provider to illness * Economic consequences to family income
Professional Responsibility
* Maintenance and adherence to licensing * Communication with other families in care * Development of contracts of service
Societal and Cultural Context
* Provision of parental leave for care of ill * Provision of alternative facilities * View of the nature and course of illness

Figure 2. Provider's decisions about caring for sick children.

Education and Training

The individual caregiver who has training in understanding the emotional, social and growth requirements of young children is more able to competently handle children with diverse needs and conditions. Those children who are ill, in fact, may respond in fashions that are not consistent with their usual patterns of behavior. Therefore, the caregiver who has knowledge of individual differences as well as children's behavioral variability in different situations would more readily be expected to accommodate to a range of behaviors from children in general. Some of these children such as those with special needs may require more guidance and structuring of activities. The capability of providers to establish a curriculum with such diverse activities would be enhanced by advanced education and training. Through experience and appropriate supervision, providers also gain increasing skill in handling difficult situations and children in difficult circumstances.

Recognition of Illness

The sensitivity of providers to symptoms of diseases in young children may be gained through experience with children and through education. Since not all diseases are infectious or chronic, the providers require current information on childhood diseases and disorders. In many communities, there are regional hot-lines or visiting nursing who consult and provide support to child care providers giving them more confidence to make decisions about acceptance or rejection of children based on public health considerations.

Provider's Susceptibility to Pressure

This is a complex factor based on personal, interpersonal and economic levels. At a personal level, the differences in providers' personalities, e.g. anxiety level, desire to please etc. may increase or decrease the likelihood that they would react to pressures by parents to accept a child.

The interpersonal level involves the relationship between the provider and the parent. If the relationship is defined as one of business the decision-making process will be different than if the relationship is defined as one of friendship. Even when the relationship is perceived by both as a business relationship, the nature of the business relationship can alter the amount of pressure exerted on the provider. For example, if the parent and provider see the business as chiefly a service then pressure may be exerted on the caregiver to provide a service for a price.

The economic level is influenced by the providers' needs to have the income from the child's presence and by the providers' awareness of legal liability. Those providers who contract with parents so that payment is received even when children are ill is planning appropriately for contingencies. As well, providers who are concerned about their financial and legal liabilities when exposing other children to dangerous/threatening situations or when dispensing medicines to sick children may be cautious about accepting sick children and resist pressure.

Home and Family

The personal life situations of the caregivers will impact on the decision to accept ill children. If there is no physical space to isolate a sick child, providers may find it more difficult to incorporate ill children into the home without creating discomfort for the ill and/or other well children. In addition when an ill child is present in the home or center, there is an increased probability that the family of the caregivers or the caregivers themselves also

may become ill. This then increases the likelihood that other consequences such as loss of work days or school days may occur.

Professional Responsibility

Early childhood educators who are members of professional associations are provided with ethical and professional standards that will guide their decision making. Through contact with professional groups, individual providers become increasingly knowledgeable of legislation within their communities. Often such legislation and government policies mandate when sick children should be accepted into care.

Part of the professional responsibility of early childhood educators is to inform the children's families of the occurrence of diseases among the children. This often is a sensitive issue when the scientific knowledge about a disease such as AIDS is being debated.

The development of service contracts between parents and child care providers enhances the professional relationship and clearly delineates the expectations of parent and provider including the charges and the basis on which decisions are made.

Societal and Cultural Context

The broader political and social environment also impacts on the decisions made by both parents and providers. Bronfennbrenner's model (1979) provides a theoretical base for this part of the model. In countries where there is a philosophical belief that parents should care for their children when in need, there may be employment provision including days off for the care of relatives contained in government legislation. Such legislation becomes part of the general social welfare contract. In other cases, days off may be seen as a work force issue that is resolved through management-employer negotiation.

Legislation in many jurisdictions mandates procedures for handling children with special needs and specifically for those with infectious diseases. Unfortunately these laws and policies are not always monitored and enforced since public accommodation for sick children is not always available.

Agencies, private enterprise and public sector groups may establish services for the care of the ill by having home or centers specifically designed for sick children. Often such alternatives are more viable in larger communities.

Finally the value systems of the families and of others in the community impact on what is believed to be the best care for sick children. These value systems generally influence how individuals believe they should act when

they or others are ill. Do you prepare hot chicken soup? Do you read a story? Do you believe work is the only cure?

Conclusions

The care of sick children involves decision making by society, parents, and early childhood educators. The relevant considerations made by each requires analysis if appropriate care is to be provided for young children and their families. Information gained from family day care providers provides a base to assess the importance of this issue to them and the relationship of the concern for families with sick children to other aspects of child care.

The proposed model is developed so that practitioners, policy makers and researchers may focus on these forces and their multi-level impact. Also this paper guides child care providers through the forces that they may overlook in their daily decision making and assist them in informing the families and community.

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