Preventing Unintentional Childhood Injuries (0 – 8 years old)

A guide for local governments and service providers setting up a community-based child injury prevention program
Acknowledgements

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This publication is also available on the Department of Human Services website at: http://www.health.vic.gov.au/injury/safestart.htm
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute for Health and Welfare</td>
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<tr>
<td>AMES</td>
<td>Adult Multicultural Education Services</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse Groups</td>
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<td>CFA</td>
<td>Country Fire Authority</td>
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<td>CGD</td>
<td>City of Greater Dandenong</td>
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<td>DHS</td>
<td>Department of Human Services</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MFB</td>
<td>Melbourne Fire Brigade</td>
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<td>MUARC</td>
<td>Monash University Accident Research Centre</td>
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<tr>
<td>RACV</td>
<td>Royal Automotive Club of Victoria</td>
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<tr>
<td>RCH</td>
<td>Royal Children’s Hospital</td>
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<tr>
<td>VISAR</td>
<td>Victorian Injury Surveillance and Applied Research</td>
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</table>
Foreword

SafeStart is a Victorian State Government initiative funded by the Department of Human Services (DHS). The initiative focuses on the prevention of unintentional injury in children through working with local governments and communities. Unintentional injury is a national health priority and remains the leading cause of childhood death.

SafeStart supports a community development, participatory action model, with strategies that focus on building partnerships, awareness raising, training and education, risk reduction, supportive policies, practice changes and resource use. SafeStart was funded initially for 18 months in three local government demonstration sites: Shire of Yarra Ranges, City of Ballarat and City of Greater Dandenong. The City of Greater Dandenong secured supplementary funding to develop this Best Practice Guide.

This guide was developed by the City of Greater Dandenong (CGD), modeled on the City of Greater Dandenong’s SafeStart experiences and successes. The guide provides information that supports local government and other service providers in responding to local child injury issues. Recommendations from the initial City of Greater Dandenong SafeStart project have been incorporated.
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Part 1: Background

1.1 Child Injury

Size of the Problem

Injury prevention is identified as one of the six National Health priorities with child injury prevention being an important health priority.

- Injury is the leading cause of child death and one of the main causes of hospital admission and emergency department attendance in Australia (AIHW, cited in DHS, 2001).
- Each year about 300 children aged 0-14 die and 60,000 are hospitalized by unintentional injuries.
- Disability or death from injury significantly affects families and the local community so the overall impact of the injury is difficult to assess.

Risk Factors

The majority of injuries to children under 5 years old occur in the home and reflect their age and stage of development (Towner, cited in DHS, 2001).

- Young children under 5 years of age are most at risk of unintentional injury.
- Males have higher rates of injuries compared to females (cited in DHS, 2001:6).

Burns, scalds, poisoning and drowning or near drowning, are the most common injuries in children under 5 years of age (Moon, in DHS, 2001:3).

There is a significant difference in child safety knowledge related to socio economic status (Colley, 1994), with risk of injury rising steeply with poverty, single parenthood, low maternal education, young maternal birth age, poor housing, large family size and parental drug and alcohol abuse.
Two reasons for this are cited. Firstly in lower socio economic areas there are fewer resources to make homes safer. Secondly, lower socio economic status is associated with beliefs about inevitability of injuries, while higher socio economic status is associated with beliefs about preventability of injury (Hazard Ed No. 49, 2001/02).

1.2 Child injury Prevention

It is therefore necessary to understand the local community when attempting to design interventions (Moodie, in Hazard Ed No.49, 2001/02). Individuals and groups have a greater chance of responding to health prevention initiatives if a multifaceted approach is used.

Approaches as emphasized in the initial Safestart project plan and interventions. (cited in DHS, 2001:26), include the following:

- Education, e.g. media stories
- Behavioral, e.g. use of car restraints
- Environmental, e.g. use of home safety products
- Legislation and regulation, e.g. smoke detectors

However, there are also pieces of research that recommend more targeted interventions such as car restraint use, smoke alarms and regulation of hot water temperatures. Evaluation is of major importance. A project is still valuable even if it shows a particular invention does not reduce injuries, as it saves further time and resources being utilized. (Thompson and McClintock, 2000)
1.3 The Role of Local Government

Under the Municipal Public Health Plan, local governments have a leading role and responsibility in providing a safer and healthier community and environment (The Local Government Act: 1958). Local government has the potential to include child safety initiatives within the wide range of services and resources that it provides.

Child safety may also be included within the broad range of local information and community promotion strategies, from the local council newspaper, display boards and telephone on-hold messages to local festivals and events.

Community capacity can be developed through a range of local government supports provided to local agencies and groups, including community grant funding, the development of new local programs or partnerships with other agencies.
1.4 The Greater Dandenong Story

Child injury prevention is recognized as a child health priority in the City of Greater Dandenong, with almost one in ten children aged between 0-5 years of age sustaining an injury requiring hospital treatment in a three year period (MUARC, 1999-2001).

The main aim of the Greater Dandenong project was to develop locally appropriate strategies to minimize the risk of child injuries in the home, particularly falls, poisoning burns scalds and electrocution. The project targeted parents and carers of children aged 0-5 years in Arabic, Cantonese, Khmer and Vietnamese speaking communities. These communities represented the four main languages other than English spoken by families with children aged 0-5 years residing in CGD at the time.

SafeStart was implemented and managed within the Maternal and Child (MCH) service. The main advantages were:

- Maternal and Child Health and Safe Start shared similar aims and objectives
- The MCH service provided ready access to families in the SafeStart target population. i.e. families with children 0-5 years

1.4.1 Successes

Recognition of the value of the multi cultural nature of the project was received via a Certificate of Nomination in the 2003 Fire Awareness Community Services Award, Multicultural Category. SafeStart was also highlighted as an innovative project in the ‘Access and Equity 2004 Annual Report: Progress in the Implementing the Charter of Public Service in a Culturally Divers Society (Department of Immigration, 2005). The report highlights contributions from state and territory governments in relation to providing services to their culturally and linguistically diverse residents.
Some successes were:

- Development of the Safe Smart Homes Booklet which was translated into four languages and English. (See 3.1.1; p 17).
- SafeStart gained four Peer Educators; Chinese, Vietnamese, Cambodian and African, thus increasing and promoting the safety message in these communities.
- The Maternal & Child Health team received updated child safety training including current safety products available to families.
- A Community Development Officer continues to work in partnership with internal and external stakeholders to maintain and increase child safety information and awareness raising activities e.g. Multicultural First Time Parent Groups child safety sessions continue to be scheduled, at Bunning’s Dandenong ‘Home Safety Display House’
- Improved staff and community access to child safety resources (particularly translated resources).

1.4.2 Challenges

SafeStart was undertaken during a relatively short time frame. Limited time was available for developing ongoing relationships and partnerships and building long term strategies into existing structures and policies.

Key service providers and CALD community leaders experienced competing demands on their time and resources, so that progress was delayed at times.

Whilst it is understood that high risk families are in the greatest need of safety information, other more immediate needs e.g. housing, income and transport are more immediate and important, so that gaining the attention and interest of these families was challenging.
Part 2: The Best Practice Guide

When setting up a Community based Child Injury Prevention Program the following strategies are recommended

2.1 Gather information
2.2 Partnership development
2.3 Program Planning (including planning for effective evaluation)
2.4 Program implementation
2.5 Conducting the Evaluation

2.1 Gathering Information

The gathering and documentation of information and resources can be time consuming, however best practice dictates that all aims objectives and interventions are evidence based.

Choose from the child safety information available items that are most relevant and most suitable for translation. A working group consisting of Maternal and Child Health and Children’s Services representatives will promote eventual ‘ownership’ of the material selected by the teams to utilize it. This material should be reviewed annually.

Researching statistical and local data and evidence based literature will help to define issues and determine the project plan, e.g. the majority of unintentional injuries to children under 5 years old occur in the home.
2.1.1 Community Statistical data

Local governments will have most of this data on hand.

<table>
<thead>
<tr>
<th>What information is needed?</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic profile</td>
<td>ABS, DHS, Council</td>
</tr>
<tr>
<td>Dominant culture/s, language/s, language barriers, ethnicity, population or Aboriginal community</td>
<td>ABS, DHS, Council e.g. MCH data</td>
</tr>
</tbody>
</table>

Statistical data is easier to understand and use if presented in an analysed format, for example as charts and graphs. This is particularly useful if the information is to be distributed within the community.

2.1.2 Child injury data

This may be the first time council has attempted to gather and document child injury activities locally. This exercise provides an opportunity to identify and celebrate past child injury prevention achievements.

<table>
<thead>
<tr>
<th>What information is needed?</th>
<th>Sources</th>
</tr>
</thead>
</table>
| What do child injury statistics say about the local government area? This will assist in determining the size of the child injury problem | • Specific and general child injury data is available from VISAR and MUARC.  
• General information is available from the Royal Children’s Hospital Safety Centre, KidSafe.  
• Emergency Services such as the CFA keep some data too. |
| Previous child injury prevention strategies implemented in council or the community. Were they evidenced based? What were the outcomes? | • Council: Social Planning, Recreation, Family and Children’s Services, Family Day Care, Community Safety, Bi-laws e.g. finger jam, driveway deaths, dog handling.  
• Emergency Services; Early Fire Safe (CFA and MFB.), Crawl Low In Smoke, Winter and Summer campaigns programs.  
• RACV e.g. Child Restraints  
• VicRoads e.g. Stop Look and Listen |
What information is needed?  Sources

| Existing polices, plans and practice that support the project. | Council: Community Safety Plan, Social Development Policy, Recreation Plan and the Municipal Public Health Plan. |

Incorporate strategies into the project and build on them. Think about the uniqueness of the local area. Are there special considerations?

2.1.3 Evidence Based Literature

Examination and exploration of current research and literature provides a more comprehensive understanding of child injury prevention and intervention and information regarding many trialed and proven strategies. Child Safety information on the Web and the references cited in section 3.2 and 3.3 are recommended.

2.2 Partnership Development

One definition of a partnership is: “A partnership exists if the relationship between the project and another organization, agency or individual produces a tangible benefit to the project. The contribution by the partner can be in the form of a service, sponsorship, advice or other benefit. The partnership can be temporary (known period), ongoing (indefinite period), or sustainable (long term) during or after the conclusion of the project’. (MUARC: 2000)

Coming together in an atmosphere of trust and sharing commitment to the development processes required to build effective partnerships takes time. Strong partnerships have sustainable relationships and are resilient.
Partnerships can include:

**Partnership type** | **Groups / Agencies**
--- | ---
**Primary partnerships** | Community Health Services, hospitals, Medical Practitioners, Emergency Services, Local government Departments (Children’s and Family Services, MCH, Community Safety, Social Planning), playgroups, parent groups, social support groups, Family Day Care, childcare and kindergarten groups, primary schools, out of school care and service provider networks.

**Secondary partnerships** | Businesses, trades, utility services, Chamber of Commerce, hardware, pharmacies, utility organizations, media, radio, trades, building and plumbing services, Township committees.

**Tertiary partnerships** | TAFE’s, language and literacy centres, neighborhood houses, Migrant Resource Centres and community centres, RCH.

### 2.2.1 Identify possible partners

Strategies are more likely to be sustainable if local families and agencies participate.

Therefore, firstly consider the local community and what particular groups or individuals might be supportive of the project. An article in the local paper could be used to identify local interest. Another strategy is to hold a public meeting or to speak at a local network group meeting. Consider, in particular, partners who could build child injury prevention strategies into their existing programs and services.

Once possible partners have been identified, approach the agency or group to explain your planned project and the possible ways that they could be involved. Indicate the perceived suitability and the benefits that it is believed
that they will experience. Document the partnership arrangement so that each has a clear understanding of their role in the partnership.

### 2.2.2 Partnership Management and Coordination

A key step for establishing a community based child injury prevention project is to establish a reference group. The Reference Group will provide guidance and support for the project. Members of the Reference Group usually represent all key stakeholders, i.e. the partners and any sponsors involved.

### 2.3 Program Planning

When planning, implementing and evaluating child injury prevention, there are key steps to ensuring quality practice. These steps are collectively known as program management:

![Figure 1: The cyclic nature of program management for health promotion](image-url)
2.3.1 Selecting the target group

Before the target population can be identified the extent and nature of unintentional childhood injuries in your community must be understood. The information gathered (see 2.1.1 and 2.1.2) will be invaluable in identifying the nature of accidental childhood injuries in your community and the most appropriate target population.

The aims, goals, objectives and strategies of the project will be directed to the target group and to the presenting issue.

For example:

**Goal:** To prevent child injury in children 0-8 years of age by effectively targeting families with children 0-8 years from Vietnamese, Cantonese, Cambodian and Arabic speaking communities.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>To identify needs and develop culturally appropriate child injury prevention initiatives through community consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies</td>
<td>Develop, translate and administer questionnaires to parents in the target group to determine service needs and baseline information</td>
</tr>
<tr>
<td>Partners</td>
<td>Include Vietnamese, Cambodian, Arabic and Chinese speaking representatives in the Steering Committee</td>
</tr>
<tr>
<td></td>
<td>Council Economic Development Unit, SafeStart Reference Committee</td>
</tr>
<tr>
<td></td>
<td>Maternal and Child Health Services, Children’s Services, Family Day Care</td>
</tr>
<tr>
<td>Target Group</td>
<td>Parents with children 0-5 years in the identified CALD communities.</td>
</tr>
<tr>
<td>Key Performance indicators</td>
<td>Steering Committee established with representatives from each CALD group</td>
</tr>
<tr>
<td></td>
<td>No. of questions circulated and received from each group and data collated.</td>
</tr>
<tr>
<td>Timeline</td>
<td>Established</td>
</tr>
</tbody>
</table>

Consider the geographical spread of the target group and length of the project when planning for the delivery of strategies.
2.3.2 Developing Project Goals, Objectives and Strategies

Planning for health promotion action must begin with being clear about the broad priorities and using these to develop program goals and objectives. An overview of goals and objectives is provided in the Victorian State Government Integrated Health Promotion Resource Kit (Chapter 4). Hawe et al (1994) also provide detailed information on preparing program goals and objectives.

The **goal** is a statement about long-term outcomes or benefits. These are broad statements that relate to improving health and wellbeing status through changes in mortality, disability, quality of life or equity. In the case of childhood injury prevention, this would relate to reduction in the number of deaths or disabilities as a result of injury.

**Objectives** describe the ways in which you plan to operationalise and achieve your goal. They state what changes and achievements must
occur for the goal to be reached and what the program is meant to achieve immediately after its completion. It is therefore crucial that your objectives are clear and concise.

A good tool for developing sound objectives that will guide program development and evaluation is to ensure they are SMART:

- **Specific** (clear and precise)
- **Measurable** (amenable to evaluation)
- **Achievable** (realistic)
- **Relevant** (to the health issue, the population group and your organization)
- **Time-specific** (timeframe for achieving your objective).

**Strategies** are actions taken to achieve the program objectives.

### 2.3.3 Planning for Effective Evaluation

Evaluation is an important component and should be ongoing throughout the life of the project. Evaluation should be considered at the conception and planning of the program so that the most relevant and useful data is collated, and time and funds are allocated specifically for the evaluation process. (Also see 2.5)

**Why evaluate?**

The information and feedback gathered during the evaluation can be used for a number of purposes:

- To ascertain ways to improve the program or to explore a particular issue in more depth.
- To target specific groups that may not be participating in the program e.g.; culturally and linguistically diverse groups or teenage mothers, so that the design of the program can be altered to include diverse groups.
- To modify planned interventions according to their success.
- Successful strategies can be incorporated into Council core business and practice
• To determine that the objectives of the project are being met successfully.

• To gather numerical data — This data may be used in the organization’s annual report, for reports required by the funding body, for budget reports or demographic data for resource allocation.

• To justify the program continuation and to support funding applications. This may include numerical data and feedback about the program from participants.

Internal or External Evaluation

There are benefits and barriers of having internal or external evaluation that should be examined before funding is allotted for the chosen process. Some of these are listed below.

<table>
<thead>
<tr>
<th>Internal Benefits</th>
<th>Internal Barriers</th>
<th>External Benefits</th>
<th>External Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate project knowledge</td>
<td>Lack of expertise, methods and forms</td>
<td>Greater expertise</td>
<td>Removed from project</td>
</tr>
<tr>
<td>Greater ownership &amp; empowerment</td>
<td>Bias &amp; subjective</td>
<td>Impartial &amp; objective</td>
<td>Less ownership &amp; empowerment</td>
</tr>
<tr>
<td>Less costs</td>
<td>Not recognized</td>
<td>More recognition</td>
<td>Greater costs</td>
</tr>
<tr>
<td>Close collaboration with community</td>
<td>Resource poor</td>
<td>Greater resources at finger tips</td>
<td>Community collaboration limited</td>
</tr>
<tr>
<td>Close proximity to the project</td>
<td>Time consuming</td>
<td>Have IT programs &amp; statistics ready</td>
<td>Concentrate on evaluation</td>
</tr>
<tr>
<td>Can concentrate on implementation</td>
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</tbody>
</table>
2.3.4 Considering the Budget

A three to five year project is recommended as this provides plenty of time for planning, developing partnerships and evaluation. If funding is restricted, an alternative could be to employ a project officer for 3 days a week for 3 years as opposed to full time for 18 months. A part time administration officer to support the Project Officer would enhance the number of activities able to be achieved particularly in a short term project.

A detailed budget should be developed in the planning stage which includes the cost of staffing and resources required. It may be helpful to brainstorm project needs with the reference group. The scope of the project will also be limited by the amount of available funds. Remember to include costs such as advertising, payroll costs and travel.

2.4 Program Implementation

2.4.1 Implementation Models

There are numerous implementation models that could be considered depending on the resources available, the agencies and individuals involved, the level of direct community involvement and the relevance to established agencies and partnerships. Some examples are given below.

Community Development

“There is the development and utilization of a set of ongoing structures which allow the community to meet its own needs and involves changes at personal and social levels”. (McArdle, J: 1989).

Community Leadership

Utilizes recognized and respected community leaders e.g. Chamber of commerce, local churches and community service groups, township committees.

Community Working Groups

People who are interested in child injury prevention and work together to develop a locally based action plan to implement locally e.g. parents, carer’s, service providers, CALD groups.
Peer Educators
Similar to Community Working groups but are responsible for the delivery of education methods to their peers e.g. Parents with young children delivering to parents with young children. They may come from the Community Working group.

Social Marketing
A social marketing approach engages community groups to ensure the injury prevention message is spread in ways that are relevant and meaningful to the target groups. A social marketing approach is most effective in engaging the community within a tight timeframe and in spreading awareness of a specific message.

N.B.
• Allow plenty of time to plan for the implementation phase. This will give greater flexibility for challenges encountered along the way and in meeting community expectations.
• Difficulties can be prevented in the planning phase if a workshop is held to identify possible barriers and their solutions.
2.4.2 Health Promotion Strategies

Promotional Activities

When raising community awareness of child injury prevention key messages should be developed, duplicated and consistently used in media, for the development of resources and for education and training e.g. most childhood injuries happen in the home and in motor vehicle accidents.

A range of promotional activities can be undertaken. Some promotional activities are opportunistic e.g. a radio station providing a session on child safety after a localized child injury incident.

Some publicity activities can be opportunistic and reactive by nature e.g. a radio station providing a session on child safety after a localised child injury incident.

Council on hold voice messages:
If council informs the community about the project, contact details for further information should be provided. To increase response it is recommended that a prompt be used and an incentive be given e.g. Contact the Project Manager on (phone number) if you would like to receive a free bath thermometer.

Council community newsletters delivered to every household in the municipality:
Are a very successful medium for project promotion because they reach a large number of the target group.

Council web site:
A particularly valuable tool with the increase in computer and internet use.

Council Information Bulletins:
In particular to keep Councillors informed.

Media releases:
These are reliant on editorial space and may not appear when or where wanted. This reinforces the need to fund newspaper advertisements to
promote events and build partnerships with local newspapers. Some newspapers will add equal or proportionate editorial space if advertising is purchased. A competition or questionnaire can enhance editorial and advertising and can provide invaluable information e.g.: Community perception versus the reality of community safety. Check with your organisation’s media departments on media releases as policies can vary greatly.

**Displays and presentations:**
Include manned displays, static displays, presentations, children’s story time at local libraries, child safety family day events and any event that especially meets the target group. CALD groups are more likely to look at displays, ask questions and take information if CALD Peer Educator’s are present. Settings can include for example, language and English schools, larger hardware retail outlets and the Seniors Expo.
Radio interviews:
This activity provides the opportunity to promote the project and child injury prevention strategies locally.

Service provider’s networks and training calendars:
These sometimes have a database that could be shared.

Safety Products and Giveaways
Utilizing child safety products in health promotion sessions will increase awareness of their availability and use. A child safety kit including product giveaways provides hands on experience and encourages attendance. See 3.1.3

Translation of Child Safety Information
Choosing the most appropriate material is essential when choosing resources for delivery to English and CALD groups and identifying material for translation. There is an abundance of material available that can overwhelm the community and service providers and information can be outdated, conflicting and confusing. A working group consisting of Maternal & Child Health and Children’s Services representatives will promote ownership and usage by the teams represented. All material should subsequently be reviewed annually. Child safety information
and resources in CALD languages and in English are available from a range of organisations, including the Royal Children’s Hospital Safety Centre, KidSafe, FarmSafe, The Poisons Information Centre, SIDS Australia, Consumer Affairs, C.F.A and M.F.B fire services, VicRoads and the Victorian Plumbing Commission. Some order forms are available online or from the organisation. The Victorian Translations online website links to all nationally available translated child safety information (www.healthtranslations.vic.gov.au).

Translation of brochures can only be carried out by an accredited translator preferably with some training or knowledge of child injury prevention. It is recommended that Bilingual Peer Leaders and Educators, community members and child safety professionals with knowledge and training in child safety check the content of the translation in the draft stage and provide feedback to the translator where necessary.

**Education and Training Sessions**

Time and effort spent on education and training the community is invaluable. It increases the community’s awareness of unintentional child injury prevention. Coupled with the inclusion of community members, evidence indicates that education builds sustainability into the life of the message. E.g. See Case Study 1: Safe Smart Homes Booklet (p 18). Education also supports the capacity building process which can be defined as:

“Development work that strengthens the ability of community organizations and groups to build their structures, systems, people and skills so that they are better able to define and achieve their objectives and engage in consultation and planning, manage community projects and take part in partnerships and community enterprises. It includes aspects of training, organizational and personal development and resource building, organized in a planned and self-conscious manner, reflecting the principles of empowerment and equity.” (Elkington and Gaffney (1993). Skinner (1997: 1-2)).
Accessing existing groups and programs

Providing child injury prevention education through small community group sessions provides information in detail and allows for greater sharing of experiences and question time.

Engaging kindergarten and childcare parents can be difficult as they are not static groups like playgroup parents. This can be overcome by accessing their parents through playgroups, first aid courses, immunisation sessions, newsletters, child safety information kits and other inventive activities.

Offering child safety sessions to existing groups as opposed to arranging one-off child safety sessions requires less preparation and promotion time, e.g. playgroups and first time parent groups. Also holding services in partnership with groups and organisations with shared agendas e.g. CFA’s ‘Early Fire Safe Program’ can be effective.

Peer Education

The Peer Educator model, for CALD groups, is preferable to interpreters and guest speakers. Interpreting between speakers is more time consuming and less information can be provided. Guest speakers may not be aware of the culturally sensitive issues of the group that the peer educator would be more likely to recognize. CALD groups, migrants and refugees can be easier to access through AMES English schools, Migrant Resource Centres and language and literacy centres. To gain a better understanding of the Peer Educator model see 3.1.2.

2.4.3 Information Provision

Don’t overwhelm people with too much information. The breadth and complexities of child injury prevention make it difficult to cover all components in a single child safety training or education session. Targeting topics is recommended.

Plan distribution strategies to reach the target group effectively. Key points are MCH Centres, kindergartens, Child Care and Family Day Care Centres, local hospitals, general practice, community centres, playgroups, antenatal and postnatal groups.
Consider a central distribution point for resources, to make it easier to manage the information and reduce the volume and space needed for storage.

Do ask people about their experiences with child injury. Try and work from a base of resilience rather than vulnerability to encourage participation. People are more likely to share if they are in a safe non-judgmental environment.

**Readiness to receive child safety information**

**Prenatal/Antenatal:**
While some expectant parents are focused on the birth process, others find it a time when they are more likely to read information. Avoid providing information too late, such as safe nursery furniture information after the birth, when the majority of nursery furniture has already been purchased often by well meaning relatives and friends. Consider that parents are often not interested in discussing child safety just before or just after the birth of their baby due to tiredness and adjusting to
physical and lifestyle changes. New parents are busy and can be more concerned with breastfeeding, sleeping and settling issues.

**Key developmental phases:**

Risk factors for injury vary depending on the child’s developmental age, stage and progress. (Ozanne-Smith, 1992). Parents are more receptive to injury prevention information when their child has reached a particular developmental stage. The best time, however, to inform parents is a short time before the child has reached the ‘high risk’ developmental stage e.g. removing poisons from cupboards before a baby crawls and grasps objects.

Maternal & Child Health Nurses include safety information when discussing child developmental with parents.

**Opportunistically:**

Have information readily available when approached by telephone or face to face contact occurs.

**At the time of the accident:**

While it may not seem an appropriate time to provide information to parents if they are distressed and unable to absorb information, hospital emergency staff report that sometimes parents seem more responsive at this time. Parents of an injured child often like to share their experience and information with family and friends. This can help in dealing with the event and provides an opportunity for raising awareness.

**Source of Information:**

Parents are more likely to respond to information from a credible source e.g. General Practitioner, Pediatrician, Maternal and Child Health Nurse, Registered Nurse, KidSafe and the RCH Safety Centre.

**2.4.4 Training for Service Providers**

Training can be provided to service providers, sponsors and partners, reference group members, peer educators, Family Day Care staff, kindergarten and childcare services, the Maternal and Child Health
Team, post natal units and others that have a legislative responsibility or an interest in child injury prevention.

Training can include topics such as child safety in the home and car, safety products, injury prevention and child injury statistics, small group facilitation, journal keeping and others. Consider issuing certificates on completion of training as it is found that people like recognition for skills gained.

Keep training uniform through all groups for simplicity and duplication purposes. Offer information to those who identify a specific child safety issue. To prevent information overload it is important to target a small number of child safety topics at each training session. Training updates should be held annually.
2.5 Conducting the Evaluation

2.5.1 Monitoring and Reporting the Project

The following table identifies specific methods of evaluation which will help in monitoring and reporting the successes and challenges of the project. Consider them and others and include in the initial action plan.

**Evaluation Methods**

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<td>Journal entries</td>
<td>Peer Educators</td>
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<td>Volunteer and peer educators can be encouraged to journal their experience.</td>
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<td>A consent form may be developed so that entries can be used in the evaluation.</td>
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Part 3: Useful Resources

3.1 Key Strategies developed by City of Greater Dandenong

3.1.1 Safe Smart Homes Booklet:

3.1.2 Peer Educators

3.1.3 Safety Products

3.1.1 Safe Smart Homes Booklet

The purpose of the Safe Smart Homes booklet and the accompanying poster is to provide, and give access to, child safety resources in English, Vietnamese, Chinese, Khmer and Arabic languages and increase the community’s awareness and knowledge of child injury prevention. The book uses pictures and short, simple tips for preventing targeted home injuries (including falls, poisoning, scalds, burns and electrocution), in children aged 0–5 years.
Booklet Development

A needs analysis was conducted with multicultural parent groups and service providers such as Maternal and Child Health Nurses, childcare/family day care providers, and kindergarten teachers. Also Arabic, Chinese, Cambodian and Vietnamese-speaking Peer Educators. The feedback strongly suggested a need for a photographic resource.

The booklet, and a poster promoting the booklet, were focus tested with draft English, Vietnamese, Arabic, Chinese and Cambodian mothers, Peer Educators and Leaders, CALD community workers and CALD Maternal and Child Health nurses before printing. Comments made were about the colour, font, relationship between photos and captions and interpretation of photos and captions. Translation amendments were made due to incorrect translation, e.g.: The word ‘label’ in Arabic does not make sense for clothing.

The booklets were distributed through Maternal Child Health, Multicultural Post Natal Parents groups, Children’s Services Program, the Council Kindergarten Enrollment Program and Council’s Health and Community Safety Programs.
The booklet has now become a sought after resource, being distributed widely throughout Victoria by the Department of Human Services. As well as use as a booklet, the pages may be separated and laminated for use in displays in many different settings.

**What we learnt**

There are a number of practical and strategic points to consider before beginning the development of pictorial and/or reading resources to ensure that important issues are not neglected and unfavorable costs are not incurred, i.e. printing material with incorrect information.

- Engage and consult with internal or external graphic designers from the outset and pre-view all draft versions.
- Take time to consult and ascertain the need for a particular resource prior to development.
- Including the community in photographs builds sustainability into the life of the message and supports a capacity building process. (Elkington and Gaffney, 1993).
- Consent will be needed for the use of photographs. Check with the Risk Management Department.
- A disclaimer may be necessary for information. Check with Council’s Risk Management Department.
- Some photographs may not always provide a clear message. Captions that relate to each photograph may be required and should be translated into short, key messages beside the photographs. Use a single theme or caption for each page to avoid confusion e.g. Use a child safety gate on stairs.
- The use of ticks and crosses, on people in pictures, to indicate the right and wrong safety message can be culturally inappropriate.
- Focus test the final draft version of the resource before final print as this will ensure it communicates adequately to the target population and minimizes the risk of translation errors.
3.1.2 Peer Educators

In 2002 volunteer Culturally and Linguistically Diverse (CALD) Peer educators were enlisted and trained, in the City of Greater Dandenong to deliver child injury prevention education sessions to their own communities. The target group was families with children 0 – 5 years of age. Peer Educators were chosen from the four larger CALD communities represented by Arabic, Chinese, Vietnamese and Cambodian speaking families. In 2005, they became employees of CGD, in what came to be known as Phase 2 of SafeStart.

A Peer Educator is someone who shares common characteristics with the intended audience and is therefore able to provide information from a similar perspective. They can be recruited through child safety information sessions, community leaders, Maternal and Child Health Services, children’s services, CALD groups and others. Each will bring unique skills and experiences to the project.

The scope of the activities conducted by the Peer Educators resulted in significant personal professional development and growth. Activities conducted by them included:

- Planning and conducting child safety sessions
- Flyer design using integrated language approach e.g.: English/Arabic
- Attending displays at local events/festivals
- Completing professional training courses
- Reference Committee members
- Evaluating sessions and project administration
- Assisting with and participating in photographs for the Safe Smart Homes Booklet
- Interviews on SBS radio
- Personal and work related journaling
- Participating in a focus group discussion for project evaluation
Stories from the Peer Educators

Their stories are told together using their journal entries; session plans, training notes and participant responses.

Tina (Cambodian-Khmer):
I am married with children aged 9 and 20 months. I have been in Australia for 22 years. I arrived with one of my two brothers and two sisters as refugees. I went to St. Kilda Primary School in grade 5 and 6 and I am proud of this. I was a volunteer with SafeStart until I was employed in the position. I have an Associate Diploma in Accounting and I am currently deferring a Degree in Commerce. I am a Support Worker for the Alfred Hospital and a Cambodian Interpreter and speak Khmer and English.

Samar (Arabic):
I came to Australia in 1987. I am married and I have a 17 year old boy and a 7 year old girl. I worked as volunteer front of office worker with Narre Community Learning Centre for many years. My employment and volunteer work includes the Victorian Immigrant and Refugee Women’s Coalition (VIRWC) as a Community Resource & Training Officer, City of Greater Dandenong SafeStart Project as a Peer Educator for the Arabic Community, Executive Member at the Ethnic Community Council of the South East (ECCOSE), Treasurer for the Migrant Women Wellbeing Network (MWWN), Reference Group Member for CALD Women’s Project with Victorian Migrant Centre (VMC) and Coordinator of Arabic Women’s Group of the South East. Recently I became a Commissioner with the Australian Multicultural Commission.
Le Van (Vietnamese):
I am married with two children, four and eight years old, and came to Australia 15 years ago as a refugee. My networking and volunteer work in the Vietnamese community includes helping at my son’s primary school, as a committee member for two years. I was a SafeStart volunteer and later employee. I enjoy working in the community and I have many opportunities to help the Vietnamese community. I have done Certificate 3 in Business administration and speak Chinese dialect, Cantonese, Tiu Chiu and English.

Hai Ying (Chinese):
I am married with two children, six and seven years old, and came to Australia 15 years ago as an immigrant from mainland China. My volunteer and employment work includes child injury prevention, childcare, Family Day Care, multicultural playgroup and Chinese friendship and Education Parent Group. I am a qualified Level 3 Childcare worker and I am studying for a Diploma of Counselling. I speak Mandarin, Cantonese and English.

The Training
Childhood injury prevention training (five days) was provided to the Peer Educators and focused on home and car safety, child injury statistics, small group facilitation and presentation skills, networking, keeping a journal and planning.

“I gained a lot of new information to help me in my personal life as well as helping people in my community. As an action I have been taking, I start speaking to the people in my social life about the project and how much we are in need of a project like this in other issues.”

“I knew lots of information about safety through my experience as a mum of two children, but sharing this training sessions was much more experience. I learned about fire safety, what to do in case of a poisoning case, the most common causes of falls and so on. I couldn’t wait to start my presentation.”

They knew what to do and enjoyed the opportunity to improve their English skills too!
Education Sessions

The Peer Educators delivered many small group child safety sessions, utilising their established networks. Permission was obtained to include the following comments:

"After the training, I participated in some child safety sessions and watched the child safety video, safety products and activities. I read over the child safety information, safety products and contacted the Vietnamese Community Development Worker and Project Manager to arrange a time and venue where mothers meet. When I conducted the session I did a pair exercise to get mothers to identify child injury dangers in the home, I showed the video and safety products and did evaluation feedback to find out how helpful the mothers found the session."

"I contacted the temple and president for permission for us to display and facilitate the project. He was very kind and happy for us to do a display and he found a good spot for us to display our kits and safety items."

"I prepared a speech and 10 questions in Chinese and the parents whom got the correct answer will win a prize. At our normal story time at the playgroup I used a set of photos and real safety products to show the parents and children safe things to do around your home."

"At the end of the session we gave away some chosen gift for them and I had given them an important message. Supervision is number 1 of safety."

The Peer educators noted that sessions took a lot of time to plan but really enjoyed the delivery.
Feedback from participants

The participants indicated what they learnt in sessions and how they would change things at home.

"I listen and feel impressed. I understand, I am very happy."
(Cambodian Postnatal Group)

"We didn’t know any of this information until we came ... It was good to find out where to buy corner protectors, travel knobs, fire blankets, smoke alarms and fire extinguishers."
(Vietnamese Seniors Group)

“We need to be aware of the hazards in our home that face our family every day. As my child has just started crawling it was great to see how to make the place safe.”
(New Parent Group)

“The fire blanket and covers on the stove is the most important message I received.”
(Chinese Parent Friendship and Education Group).

“I will teach my children about what we learnt in today’s session about fire safety and do the fire escape plan to save my live and my families.”
(Arabic Women’s Group)

“It’s a good meeting because when your friends say to you and advise you — maybe you will do it or not but if you are in a meeting and there is a group of women, everyone will say what happened to him and it will be a good example for safety. It was very good, I
thank everyone who helped to do this — especially Samar.” (Arabic Women’s Child Safety Session)

“Medications and hot water are the most important things.” (Vietnamese Postnatal Group)

Participants liked to share personal child injury experiences and felt that it gave them more understanding and helped support each other.

The Displays — Working together

The peer educators worked together to present displays. They enjoyed this experience and expressed feeling more confident together.

Parents, grandparents and new arrivals, migrants and refugees, went to the displays. Many questions were asked in CALD languages and in English. CALD communities preferred to speak with the Peer Educators.

“I passed a lot of information for elder people who looked after grandchildren at home. Some of them were very lack of experience about safety and the other thing … they couldn’t read English so when we got there they were very pleased.”

“We displayed child safety for Springvale AMES students who were new arrivals, some were singles and some mothers. They were very interested and happy to have the information as much as the gifts, the display went very good. Younger students said they would tell their sisters and brothers with children about the information and products.”

“On that day I felt much relax because I wasn’t the only person that people are focusing on me, it was a much easier session especially that the four of us where sharing the same table while we were representing the information. We had lots of fun and jokes.”

Parents, grandparents and new arrivals, migrants and refugees, went to the displays. Many questions were asked in CALD languages and in English. CALD communities preferred to speak with the Peer Educators.

Sharing our experiences

The Peer Educators comments accommodate a growing personal and group confidence, an interest in further study and employment and other volunteer work.
“I feel fantastic about working as a volunteer for the City of Greater Dandenong; I know more about local services and organizations for my community e.g. meals on wheels, neighborhood watch, poisons information centre, family support and counseling, CFA.”

“My manager helped me build the framework for my journal on the last day. This is the first time I wrote a long journal like that. It was hard for me but I had the framework. It was helped me a lot.”

“Know more about the local council and gained confident to seek job opportunity in this area.”

“I really like the ideas and the environment of working with other migrants from different backgrounds.”

“SafeStart has provided a springboard to enroll in further studies and participate in community development opportunities e.g. Multicultural playgroup leadership training, ‘Step into Volunteer Work’ Certificate II in Community Services.”

“Being able to use the child safety information in a variety of roles as a family day carer, peer educator and leader of parent groups and playgroups.”

Learning together gave the Peer educators great enjoyment and satisfaction.

**Benefits**

The Peer Educators were proud that they could offer information to their family and friends about child safety. Their communities and cultural and social networks have benefited from this.

“After hearing my advice, one of my friends had changed their children’s bed bunk to two single beds. They told me their family felt safer and happier about the bed now.”

“The impact of the project on me was of great benefit, even with my experience as a mum I found a lots of wrong things I been doing and I wasn’t aware of it so I did learn a new skill, my daughter was so happy knowing SafeStart project she even asked her teacher to host me and make a presentation to her class… she even told her friend about some of the rules, like they shouldn’t sit in the front
seat in the car before they are 8 year old. She always uses the hot water thermometer.”

“One day my friend was showing to me some papers that her son brought from school, she couldn’t understand what these papers are for. When I read it I discover that this paper is a project to teach the child about a fire escape plan. I explain everything to them; I helped them to make this plan, my friend was so happy to ask me because she didn’t know what to do. I was very happy that I could express the information I been learning through my training in a very simple way.”

The Peer Educators comments indicate a wealth of diverse social connections that has positive benefits in influencing those around them.

**Challenges**

The Peer educators noted a number of challenges experienced by them including cultural and language difficulties, disappointments and fears and they worked together to understand and overcome them.

“I felt very strange to be in a formal meeting and eating, (for me it is a bit rude to eat and talk), especially at work meeting, so I had some drink but I wasn’t happy … after a few meeting when I started to be familiar with this team, I realized that most of them are working together in the same centre and having this type of meeting is usual, and they are really nice people.”
“Having time to attend the training and prepare the sessions and activities. To prepare and run the session smoothly and try to give as much as possible information to the parents in a 2 hour session with children around them and answer all the questions.”

“To feel comfortable to speak out in meetings when there are a lot of people.”

“The session went very good; the only problem was the accent. I speak Arabic Lebanese accent, the African speak Arabic African, so it was very hard to understand all the words and the terms I’m using or what they are using so I had to compromise by using the English language and easy Arabic.”

Many of the challenges experienced were communication problems which could be over come with specific training in communication.

### 3.1.3 Safety Products

We used simple and easy to install safety product giveaways such as Velcro latches, doorstops, outlet plugs. Products that require screwing or nailing may require a trade’s person, which can be costly.

Safety products can be purchased from a range of places including major retail stores, hardware stores, pharmacies, baby nursery retail outlets and the Royal Children’s Hospital Safety Centre. There are many brands to choose from.

#### Giveaways

We engaged businesses through sponsorship opportunities at a local level which encouraged use of local safety products, participation and partnerships.
Standard letters were sent to local hardware stores, pharmacies, nursery furniture and major retail stores and outside businesses. The letters informed them about the SafeStart project, child injury statistics in the local area, the role of safety products and provided suggestions as to how local business be involved in the project e.g. demonstrations, donations or discounting child safety products. Several businesses provided free or subsidized child safety products. All provided a range of safety products and displays at no cost or cost price.

Child safety products were provided supplied at cost price to parent groups but the main range of child safety products were provided as giveaways. Participants could choose giveaways such as power point covers, stove knobs, Velcro appliance latches and table corner covers.

1. Rationale for the selection of safety products:

Evidence based research indicates that parents are more likely to act on safety information if it is provided with safety product giveaways. (DHS, 2001)

Also the products and actions involved became more accessible to parents on low income. Research (Paul, Redman and Evans 1992) shows that even when parents are aware of the value of safety products in preventing childhood injury, many are not likely to use devices unless they are readily available and inexpensive.

Other advantages of providing safety product giveaways verbalized by project participants were that it increased parental awareness about child safety products. Many parents stated that they did not know such products existed before the project. Studies have shown that lack of time and expertise are often quoted as factors that limit provision of injury prevention in primary care. Strategies need to be simple and easy to carry out (Clamp and Kendrick, 1998). Safety product giveaways were a simple strategy used to invite participation by other professionals such as Maternal and Child Health Nurses and Family Support Counselors and Workers.
2. Installation Issues:

Products relate to the prevention of injuries targeted in the safety program. For example:

- Stove knob covers — scald and burns
- Table corner covers — falls and bumps
- Bath strips — falls and bumps
- Velcro appliance latches — poisoning
- Padlocks — poisoning
- Power point covers — electrocution

Products were simple to use and cheap to install and did not require tradesmen to install.

Installation of particular safety products can be costly. Following installation of child safety products in the CGD, Family and Children’s Centre kitchen, a small number of products broke or were damaged from wear and tear in a short period. Based on this experience it is recommended that users:

- ask if they can return the safety product if it doesn’t fit, as not all safety products are one size fits all
- reinforce that the safety product is not a replacement for adult supervision and careful practice
• differentiate between child proof and time delay products
• read the safety product instructions for installation and use and check if tools are required for installation. If seeking assistance with installation, obtain at least three quotes from a qualified tradesman before buying the product. Check that the tradesmen is familiar with the product and its installation
• check local guides of businesses selling child safety products and a copy of the Royal Children’s Hospital Child Safety Centre catalogue to compare brands and individual suitability
• provide feedback to the manufacturer and business selling the child safety product, particularly if products defect or breakage is encountered. Contact Consumer Affairs if an issue cannot be rectified.

Part 4: Conclusion

The City of Greater Dandenong SafeStart program was developed using a community development, participatory action model. This model is tailor made to the needs of each specific community, and as such requires significant local involvement from a broad range of participants including parents, community peer leaders, professionals, local government, non government agencies, businesses and the local media. The impact of such a program within the community is experienced over a span of time and in different ways; from the obvious immediate short term activities to the long term more subtle impact on the community. For this important long term impact to be maximized, it is recommended that consideration be given, from the early planning stage of the program, to the development of potential long term resources and or community supports.

The establishment of a successful community based child injury prevention program is a valuable and worthwhile initiative and The City of Greater Dandenong extends warm encouragement and best wishes to all those considering developing a child injury prevention initiative within their community.
Part 5: References


City of Greater Dandenong (2004), Best Practice in Parent Education Paper


Department of Human Services (2001) Evidence Based Health Promotion: No 4 Child Injury Prevention. CCCH and RCH Safety Centre


Health Act (1958), Section 29A: Municipal Public Health Plans


5.1 Further Reading


Turning Point Alcohol and Drug Centre Inc (2000) Community Partnerships Kit

City of Darebin (2004) Baby, take a walk in the Park

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